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STATE OF CALIFORNIA  
DEPARTMENT OF INSURANCE

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PUBLIC HEARING  
REGARDING THE PROPOSED MERGER OF  
AETNA INC. INTO CVS HEALTH CORPORATION

ATKINSON-BAKER, INC.  
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REPORTED BY: ANDREA F. DANCE, CSR NO. 12865

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<p>1 STATE OF CALIFORNIA 2 DEPARTMENT OF INSURANCE 3 --- 4 5 6 7 8 9 10 PUBLIC HEARING 11 REGARDING THE PROPOSED MERGER OF 12 AETNA INC. INTO CVS HEALTH CORPORATION 13 14 15 16 17 18 19 Transcript of proceedings, taken at California 20 Department of Insurance, Hearing Room, 22nd Floor, 43 21 Fremont Street, San Francisco, California 94105, 22 commencing at 10:24 a.m., Tuesday, June 19, 2018, before 23 Andrea F. Dance, CSR No. 12865. 24 25</p> <p>Page 2</p>	<p>1 YASMIN PELED, Health Access California 2 BEN POWELL, Litigation Attorney, Consumer Watchdog 3 4 PUBLIC COMMENTS: 5 TANYA STEVENSON, MD, CEO of Breathe California 6 JULIAN CANETTI, President California Hispanic Chamber 7 BOB GORDON, American Cancer Society Cancer Action 8 Network 9 ANTHONY GALACE, Bridges to Health Director, Greenlining 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p> <p>Page 4</p>
<p>1 APPEARANCES: 2 3 4 INSURANCE COMMISSIONER DAVE JONES 5 DEPUTY INSURANCE COMMISSIONER JANICE ROCCO 6 SENIOR COUNSEL BRUCE HINZE 7 8 WITH CVS HEALTH: 9 THOMAS MORIARTY, Executive Vice President, 10 Chief Policy and External Affairs Officer 11 and General Counsel CVS Health 12 ELIZABETH FERGUSON, Deputy General Counsel 13 CVS Health 14 15 WITH AETNA INC. 16 KRISTEN MIRANDA, President of California, 17 Head of Western Territory 18 19 PAUL WINGLE, Vice President of Operations, Product and 20 Technology 21 22 ACADEMIC WITNESSES: 23 THOMAS GREANEY, JD, UC Hastings 24 RICHARD SCHEFFLER, PhD, UC Berkeley 25 NEERAJ SOOD, PhD, Sol Price School of Public Policy, USC DIANA MOSS (Telephonically) PhD, American Antitrust Institute LAWTON BURNS, PhD, Wharton PROVIDER WITNESSES: BARBARA MCANENY, MD, President of the American Medical Association LONG DO, Legal Counsel, California Medical Association CONSUMER WITNESSES: DENA MENDLESON, Senior Attorney, Consumers Union</p> <p>Page 3</p>	<p>1 SAN FRANCISCO, CA; TUESDAY, JUNE 19, 2018; 10:24 A.M. 2 3 COMMISSIONER JONES: Good morning, and welcome 4 to the California Department of Insurance. My name is 5 Dave Jones, and I have the privilege of serving as 6 California's Insurance Commissioner, where the 7 Department and I regulate the largest insurance market 8 in the United States, where insurers collect over \$300 9 billion dollars a year in premium, have about \$5.5 10 trillion dollars assets under management, provide all 11 sorts of necessary and critically important insurance 12 products to Californians, California's families, and 13 California's businesses. 14 We have a court reporter present who will be 15 transcribing today's proceedings. I'm going to try to 16 talk clearly and deliberately, although I do have a 17 tendency to go really super fast, and so I encourage the 18 court reporter to throw a flag if I'm going too quickly 19 or if any of you are going too quickly. 20 And of course I'm sure we'll very quickly in 21 to insurance speak, and that more uniquely arcane 22 language health insurance speak, with lots of great 23 acronyms and buzzwords which will challenge our court 24 reporter to no end, and so I encourage her to throw a 25 flag and stop us if we use some acronym or buzzword that</p> <p>Page 5</p>

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Public Hearing  
June 19, 2018

<p>1 requires further elaboration.</p> <p>2 I want to welcome all of you here today.</p> <p>3 We're also live streaming this as well, so that those</p> <p>4 that were not able to join us in our very crowded</p> <p>5 hearing room could participate, too.</p> <p>6 With me is Janice Rocco, the Deputy</p> <p>7 Commissioner for health reform and health policy at the</p> <p>8 Department of Insurance, and Mr. Bruce Hinze, our Senior</p> <p>9 Counsel on all health insurance matters.</p> <p>10 So I want to begin by welcoming as well, the</p> <p>11 representatives from Aetna and CVS Health, as well as</p> <p>12 all of the members of the public from whom we're going</p> <p>13 to have a chance to hear in a moment.</p> <p>14 This public hearing is being held pursuant to</p> <p>15 Insurance Code Section 12924, to examine the proposed</p> <p>16 acquisition of Aetna Incorporated -- which I'll refer to</p> <p>17 as "Aetna" -- by CVS Pharmacy Incorporated, a direct</p> <p>18 wholly owned subsidiary of CVS Health Corporation, which</p> <p>19 we'll be referring to as "CVS" throughout the</p> <p>20 proceeding, in a reverse subsidiary merger.</p> <p>21 And the purpose of the hearing is to look at</p> <p>22 the effect of the merger on competition in the</p> <p>23 California health insurance market, and its effect on</p> <p>24 California consumers, their access to healthcare, access</p> <p>25 to health insurance, quality of healthcare, and</p> <p>Page 6</p>	<p>1 As a holder of a California Insurance</p> <p>2 Certificate of Authority, Aetna is obliged to comply</p> <p>3 with the requirements of the Insurance Code and related</p> <p>4 California laws.</p> <p>5 This hearing will develop facts relevant to an</p> <p>6 evaluation of the ongoing compliance with these legal</p> <p>7 obligations and the potential effect of the proposed</p> <p>8 merger on this compliance, its impact on consumers, and</p> <p>9 its impact on healthcare and health insurance markets in</p> <p>10 California.</p> <p>11 As a holder of a California Insurance</p> <p>12 Certificate of Authority, Aetna must adhere to the</p> <p>13 licensing requirements of Insurance Code Section 717,</p> <p>14 which require, among other things, that the insurance</p> <p>15 commissioner must consider, first, the financial</p> <p>16 condition of the company in terms of its capital and</p> <p>17 surplus, second, the claims handling practices of the</p> <p>18 company, third, and I quote, "the fairness of methods of</p> <p>19 doing business," and fourth, any hazards to policy</p> <p>20 holders.</p> <p>21 In addition, the Insurance Code prohibits</p> <p>22 unfair methods of competition, that's contained in</p> <p>23 section 790.03, and includes specified acts resulting in</p> <p>24 unreasonable restraint of or monopoly in the business of</p> <p>25 insurance.</p> <p>Page 8</p>
<p>1 processing of healthcare.</p> <p>2 One of the things that I'm concerned about as</p> <p>3 California's insurance regulator is whether or not this</p> <p>4 merger will have any impacts on competition in</p> <p>5 California, whether it might impair competition in any</p> <p>6 way, shape, or form in California's health insurance</p> <p>7 market.</p> <p>8 Again, this hearing is held pursuant to</p> <p>9 Insurance Code Section 12924, which provides authority</p> <p>10 for such hearings, quote, "on any subject touching</p> <p>11 insurance business."</p> <p>12 Aetna Incorporation is a Connecticut</p> <p>13 corporation, and under the holding company "at," which</p> <p>14 is at Insurance Code Section 1215, etcetera. The</p> <p>15 Department of Insurance does not have direct approval</p> <p>16 authority over this acquisition because the transaction</p> <p>17 does not involve a California domestic or commercially</p> <p>18 domiciled California insurance company.</p> <p>19 However, the transaction does involve an Aetna</p> <p>20 subsidiary, which is licensed here in California, Aetna</p> <p>21 Life Insurance Company, which provides coverage to more</p> <p>22 than 1 million Californians. So certainly this merger</p> <p>23 has impacts in California potentially, and is something</p> <p>24 that we ought to be taking a look at and look at</p> <p>25 closely.</p> <p>Page 7</p>	<p>1 So the hearing is being held pursuant to the</p> <p>2 Departments of Escrutory Authority regarding these and</p> <p>3 other statutes, and also so that the Department of</p> <p>4 Insurance, and I as Commissioner, may provide findings</p> <p>5 to other state and federal agencies regarding the</p> <p>6 proposed transaction.</p> <p>7 However, and I want to reiterate this,</p> <p>8 regrettably the Department of Insurance does not have</p> <p>9 direct approval authority over these mergers because</p> <p>10 California law provides that we only have authority when</p> <p>11 an acquired company is a domiciled subsidiary or</p> <p>12 domiciled company that's being acquired, or whether the</p> <p>13 threshold for a commercially domiciled insurer is met,</p> <p>14 and it's not met in this instance.</p> <p>15 In 2016 I held hearings on three other</p> <p>16 mergers, the Health Net-Centene merger, the Aetna-Humana</p> <p>17 merger, and Anthem-Cigna mergers. However, only with</p> <p>18 the merger of Health Net with Centene did I, as of</p> <p>19 Commissioner, have direct approval authority, which in</p> <p>20 that case enabled the Department to require that Centene</p> <p>21 agreed to a number of strict undertakings as a condition</p> <p>22 of approval of the merger.</p> <p>23 I do want to note that there's a bill pending</p> <p>24 in the State senate, Assembly Bill 595 authored by</p> <p>25 assembly Jim Wood, which would give the Department of</p> <p>Page 9</p>

<p>1 Managed Healthcare, but not the Department of Insurance, 2 expanded approval authority over mergers like the one 3 today.</p> <p>4 Again, I want to reiterate to the legislature 5 that that expansion ought to apply to both of 6 California's regulatory agencies.</p> <p>7 Now the three mergers of health insurers in 8 2016 involve what are called horizontal mergers; mergers 9 involving competitors in the same industry and markets. 10 The proposed Aetna-CVS merger, in contrast, is described 11 largely as a vertical merger, involving entities at 12 different levels of supply or service within the same 13 chain.</p> <p>14 Vertical mergers raise competition concerns, 15 however, because if a seller owns their supplier, 16 barriers may be erected to make it difficult for other 17 sellers to use that supplier, especially if that 18 supplier has dominant market power.</p> <p>19 The proposed Aetna-CVS merger raises potential 20 concerns for California health insureds markets, 21 healthcare markets, and consumers. CVS has a dominant 22 footprint, not only in the retail pharmacy market but 23 also in the pharmacy benefit manager services market, 24 through its subsidiary CVS Caremark.</p> <p>25 As a PBM, CVS Caremark acts as an intermediary</p> <p>Page 10</p>	<p>1 However, that market conduct examination is 2 still ongoing, and while it is ongoing the information 3 related to it remains confidential at this time and will 4 not be discussed as a part of this proceeding. So I 5 thought it important to be very explicit about that 6 particular matter.</p> <p>7 With that, I would like to invite the 8 representatives of Aetna and CVS please to come forward, 9 and I understand that we'll have a slight change in 10 order of presentation from that indicated in our agenda, 11 and we're happy to accommodate that.</p> <p>12 It's my understanding that the representatives 13 of CVS would like to speak first, to be followed by the 14 representatives of Aetna. So welcome.</p> <p>15 there's also a very nice pot of tea that has 16 been brewed by our special counsel Bruce Hinze, and I 17 can vouch for its quality and magical elixir effects, so 18 you're welcome to have some of that. And then I see you 19 also brought other beverages as well, so that's good. 20 Nonalcoholic, of course.</p> <p>21 So welcome. Please do introduce yourselves, 22 and then we'll hear first from CVS and then from Aetna.</p> <p>23 MR. MORIARTY: My name is Elizabeth Ferguson. 24 I'm the deputy general counsel at CVS Health -- 25 COMMISSIONER JONES: Make sure to push the</p> <p>Page 12</p>
<p>1 in the drug distribution chain by negotiating prices 2 with drug companies and receiving rebates from them 3 while also establishing networks and formularies for 4 health insurers.</p> <p>5 Consolidating the retail and PBM services of 6 CVS with a major health insurer may have an adverse 7 effect on the ability of other health insurers to 8 compete in or enter the California health insurance 9 market. Such anticompetitive impacts could hurt 10 California consumers. So this hearing will investigate 11 those potential effects.</p> <p>12 Now before we begin discussion of those 13 effects and hear directly from the two companies 14 involved and all the other witnesses that have asked to 15 testify, I would like to mention that in February the 16 Department initiated investigation into Aetna Life 17 Insurance Company's processes for prior authorization, 18 utilization management, and medical director review.</p> <p>19 Information gained through that initial 20 investigation indicated the need for a targeted market 21 conduct examination of these areas, which commenced in 22 March.</p> <p>23 Our final reports of examination of any unfair 24 or deceptive practices in insurance are public documents 25 pursuant to Insurance Code Section 12938(b).</p> <p>Page 11</p>	<p>1 little button on the front of the microphone. It should 2 be green to indicate it's on.</p> <p>3 MR. MORIARTY: Hi. My name's Elizabeth 4 Ferguson. I'm the deputy general counsel of CVS Health. 5 Thank you.</p> <p>6 COMMISSIONER JONES: Welcome.</p> <p>7 MS. MIRANDA: Good morning. I'm Kristin 8 Miranda. I'm the California market president and the 9 west territory head for Aetna.</p> <p>10 COMMISSIONER JONES: Welcome.</p> <p>11 MS. MIRANDA: Thank you.</p> <p>12 MR. WINGLE: My name is Paul Wingle, and I'm 13 vice president for Operations, Product and Technology 14 for Aetna.</p> <p>15 COMMISSIONER JONES: Welcome.</p> <p>16 MR. MORIARTY: Commissioner, my name is Tom 17 Moriarty. I'm executive vice president, chief policy 18 and external affairs officer, and general counsel for 19 CVS Health.</p> <p>20 COMMISSIONER JONES: Excellent. Well thank 21 you all for attending the hearing, and we look forward 22 to your testimony after which I'll have some questions, 23 Ms. Rocco will have some questions, and then from there 24 we'll proceed accordingly through the agenda. 25 But whoever would like to start, could please</p> <p>Page 13</p>

<p>1 do so.</p> <p>2 MR. MORIARTY: I'll start. Thank you, sir,</p> <p>3 for your consideration of letting us go first.</p> <p>4 But first I would like to thank you,</p> <p>5 Commissioner Jones, and your staff for having me here</p> <p>6 today to discuss CVS Health's proposed combination with</p> <p>7 Aetna. And I also want to thank you, sir, for your</p> <p>8 leadership to this state.</p> <p>9 Most of you know us as the local pharmacy in</p> <p>10 your community, but we really are more than that. We</p> <p>11 are a front door to a path to better health. We have</p> <p>12 long been at the forefront of putting our patients'</p> <p>13 health first and improving the public health of our</p> <p>14 communities.</p> <p>15 Over the past few years we have taken bold</p> <p>16 steps that define us as a company. We have removed</p> <p>17 tobacco from our stores, we are promoting healthier food</p> <p>18 options, and we have been waging a multi-front fight</p> <p>19 against the opioid epidemic.</p> <p>20 CVS Caremark, our PBM, was the first to</p> <p>21 implement a program to ensure that opioids are being</p> <p>22 prescribed and used appropriately, consistent with</p> <p>23 centers for disease control and prevention guidelines.</p> <p>24 Our Pharmacist Teach Program brings local</p> <p>25 pharmacists to schools to talk to students about their</p> <p>Page 14</p>	<p>1 lower cost alternatives.</p> <p>2 We are offering more pricing transparency for</p> <p>3 prescribers, pharmacists, and patients as part of our</p> <p>4 commitment to helping consumers find the lowest cost</p> <p>5 prescription drugs. This includes the new CVS</p> <p>6 pharmacies, RX Savings Finder, which will enable the</p> <p>7 company's retail pharmacist, for the first time, to</p> <p>8 quickly and seamlessly evaluate individual prescription</p> <p>9 saving opportunities right at the pharmacy counter.</p> <p>10 But we have gone even further, by giving</p> <p>11 physicians actual transparency that they can use with</p> <p>12 their patients to help find lower cost drugs by</p> <p>13 providing real time member specific information through</p> <p>14 their electronic health records system at the point of</p> <p>15 prescribing.</p> <p>16 Early results show that prescribers accessing</p> <p>17 the real time benefits information through their EHR</p> <p>18 switch their patient's drug from a non covered to a</p> <p>19 formulary covered drug 85 percent of the time with an</p> <p>20 average savings of \$80 per prescription.</p> <p>21 Our proposed combination with Aetna is a</p> <p>22 natural extension of these community commitments and</p> <p>23 innovations. Our healthcare system in many ways is a</p> <p>24 work in progress. It was built for a different time,</p> <p>25 for a different consumer with different needs. It is</p> <p>Page 16</p>
<p>1 choices and the dangers of opioid abuse.</p> <p>2 We have done more than 8000 presentations</p> <p>3 nationally, touching almost 400,000 students including</p> <p>4 over 1000 presentations here in California touching over</p> <p>5 62,000 students, and our pharmacists are eager to help</p> <p>6 for more.</p> <p>7 CVS Health has donated more than 900</p> <p>8 medication disposal units to police stations in 43</p> <p>9 states, over 159 metric tons -- that's over 350,000</p> <p>10 pounds -- of unwanted medications that could otherwise</p> <p>11 have been diverted, misused or abused, have been</p> <p>12 collected and safely disposed of through this program in</p> <p>13 just the last two years.</p> <p>14 We have now expanded our program to bring 756</p> <p>15 disposal units into our retail pharmacies nationally as</p> <p>16 well, bringing our total to date to 83 disposal units</p> <p>17 here in the state of California.</p> <p>18 Nationwide the high cost of prescription drugs</p> <p>19 is one of the nation's most pressing problems and a</p> <p>20 major source of financial worry for consumers here in</p> <p>21 California, and across the nation.</p> <p>22 To address the high cost of prescription</p> <p>23 drugs, CVS Health is giving expanded tools to patients,</p> <p>24 prescribers, and pharmacists so they can evaluate</p> <p>25 prescription drug coverage in real time and identify</p> <p>Page 15</p>	<p>1 fragmented, complex, and burdensome for consumers and</p> <p>2 providers, and it is unsustainably expensive. It faces</p> <p>3 huge demographic and chronic care challenges, and too</p> <p>4 often the tug of war between entities with conflicting</p> <p>5 incentives means that the patient is not always being</p> <p>6 looked at holistically with the goal of preventing</p> <p>7 disease and improving their health.</p> <p>8 Our vision is to create a new, open healthcare</p> <p>9 model that will help consumers improve their health and</p> <p>10 simplify their healthcare experience.</p> <p>11 I would like to highlight three ways this</p> <p>12 transaction will help facilitate this vision to benefit</p> <p>13 the California consumers.</p> <p>14 First, we will put consumers at the center of</p> <p>15 their care. Consumers are looking for more value,</p> <p>16 greater convenience, and help in making healthier</p> <p>17 choices in their everyday lives. This new model will</p> <p>18 provide consumers the information and resources they</p> <p>19 need to better manage their own health and access care</p> <p>20 in more convenient community settings at an affordable</p> <p>21 price. The combined company will be able to better</p> <p>22 understand patients' health goals, guide them through</p> <p>23 the healthcare system, and help them achieve their best</p> <p>24 health.</p> <p>25 It will also mean expanded opportunities to</p> <p>Page 17</p>

<p>1 bring appropriate healthcare services to consumers every 2 day, where and when it is convenient for them and to 3 complement the care provided by their physician and 4 medical teams so they have the support they need to stay 5 healthy between physician office visits.</p> <p>6 Second, we will focus on prevention, primary 7 care, and chronic conditions. The combination of our 8 companies will giving physicians, and us, a more 9 holistic view of a patient's health. On average 10 patients see their pharmacists much more often then they 11 see their doctor, and many patients see multiple 12 physicians, but only see one pharmacist.</p> <p>13 We hope to build on that point of continuity 14 by having pharmacists engage patients early and often, 15 to help prevent and manage illness much more 16 effectively. Programs including one-on-one counseling 17 between a patient and a pharmacist are two-to-three 18 times more effective at improving medication adherence 19 than other interventions and result in a cost savings of 20 \$6 for every \$1 invested.</p> <p>21 Pharmacists want to practice at the top of 22 their license and help patients on their path to better 23 health. By combining pharmacy and medical information, 24 pharmacists will be better able to help coordinate 25 population health, provide information from the doctor</p> <p>Page 18</p>	<p>1 counseling once a diabetic is diagnosed, and be able to 2 more effectively deploy digital tools that make it more 3 convenient for patients to manage their care.</p> <p>4 For patients this will mean enhanced care in 5 between physician visits. For example, through 6 face-to-face counseling with their pharmacists who sees 7 them more regularly. Expanded use of digital tools such 8 as remote monitoring of key indicators such as blood 9 glucose levels. When needed, patients would receive 10 text messages to let them know when their glucose levels 11 deviate from normal ranges. Follow-up care such as 12 personalized counseling on how to manage medications 13 safely and effectively. Information on where to pick up 14 diabetes related supplies, and counseling on weight loss 15 and programs designed to address diabetes through 16 nutrition.</p> <p>17 Today these types of interventions are often 18 offered in an ad hoc or fragmented way that aren't 19 convenient or seamless for consumers. As a combined 20 entity, we will seek to better coordinate and support 21 the care that consumers are seeking across all 22 healthcare settings.</p> <p>23 Put simply, to make real progress on behalf of 24 consumers and the healthcare system, we have to break 25 the current logjam. We know health can only improve if</p> <p>Page 20</p>
<p>1 to the patient at the pharmacy counter, and give 2 patients tools to more effectively manage their health, 3 which will patients on track with their physician care 4 plans in between physician office visits.</p> <p>5 Because of Aetna's broad healthcare provider 6 networks, the combination with Aetna will provide the 7 framework for us to build better communication 8 technology between doctor, pharmacy, and patient, which 9 we will then make available more broadly through other 10 health plan providers nationally.</p> <p>11 And third, we will find ways to address the 12 rising cost of healthcare. Aging populations and the 13 rise of chronic conditions such as diabetes and heart 14 disease are two of the biggest trends threatening to 15 bankrupt our current system.</p> <p>16 Diabetes is one key area where we have an 17 opportunity to reshape the delivery of care. An 18 estimated 10.7 million California residents, or 19 38 percent of the population, have prediabetes. As a 20 combined company, we will be able to achieve the highest 21 potential in proactively helping our patients avoid the 22 complication of diabetes.</p> <p>23 For example, with our combined assets we will 24 be able to deliver preventative counseling for 25 prediabetics, provide more frequent interactions and</p> <p>Page 19</p>	<p>1 consumers are connected to support from their providers 2 and pharmacists who live in their communities and 3 understand their personal experiences. That is also why 4 current Aetna members will continue to have access to a 5 broad range of pharmacy options, both chains and 6 independents.</p> <p>7 Healthcare, like politics, is very local. In 8 the state of California we have over 1100 pharmacies, 9 27,000 employees, and last year filled over 103 million 10 prescriptions, and handled over 96 million claims. Our 11 3,674 pharmacists work with Californians every day to 12 help them on their path to better health.</p> <p>13 At 57 doctor owned MinuteClinics in 14 California, the nurse practitioners diagnose and treat a 15 variety of lower acuity health conditions, perform 16 health screenings, monitor chronic conditions, provide 17 wellness services, and deliver vaccinations.</p> <p>18 MinuteClinic is proud to be the first retail 19 clinic provider to earn accreditation from the Joint 20 Commission. MinuteClinics play an important role in 21 filling gaps in care. About half of the patients who 22 come in to a MinuteClinic, do not currently have a 23 primary care provider. Our first step is to provide the 24 patient with a list of physicians in their area who are 25 accepting referrals. In the past year alone we have</p> <p>Page 21</p>

<p>1 made three-and-a-half million physician referrals for 2 the MinuteClinic patients who did not have a primary 3 care physician when they visited.</p> <p>4 About half also come to MinuteClinic on 5 evenings and weekends when primary care is less 6 accessible. As a recent Consumers Report article on the 7 use of urgent care and walk-in clinics states, quote, 8 "When used properly, these newer options can make it 9 easier for to get the care you need, when you need it, 10 and save you time and money, too." End quote.</p> <p>11 A patient with the flu who does not have a 12 physician can get convenient, inexpensive care at a 13 retail clinic even on the weekend before their condition 14 worsens. This can prevent a costly emergency room visit 15 or costly hospitalization, improving health and saving 16 resources for both consumers and the entire healthcare 17 system.</p> <p>18 One peer reviewed study of CVS Health's own 19 employees show that those who use MinuteClinic had 20 8 percent lower overall healthcare costs compared to 21 matched nonusers.</p> <p>22 Before I answer the six specific questions the 23 Commissioner has asked us to address during this 24 hearing, I would note that later today you are going to 25 hear testimony from Consumer Watchdog. As you are</p> <p>Page 22</p>	<p>1 competition in California will remain robust to the 2 benefit of patients and payers.</p> <p>3 There is a track record of successful PBM and 4 health insurer combinations today. That track records 5 collides United Healthcare and Optum RX, which is a 6 leading health insurer and fast growing top three PBM. 7 Humana, which is a leading health insurer and 8 top five PBM.</p> <p>9 Prime Therapeutics, which is a top five PBM 10 owned by over a dozen Blue Cross Blue Shield plans. 11 And Anthem, the second largest health insurer 12 in this country, which recently announced its plans to 13 launch a new PBM business called IngenioRX.</p> <p>14 This is a complementary transaction with 15 minimal overlap in Medicare Part D. Our businesses and 16 areas of expertise differ. Our acquisition of Aetna 17 does not further concentrate the healthcare sector. 18 Instead, it reconfigures it to bring together disparate 19 parts of the healthcare system that today lead to 20 inefficient, ineffective, and more costly care.</p> <p>21 The healthcare sector will not be losing a 22 pharmacy, it will not be losing a health plan, and it 23 will not be losing a PBM. No player leaves the field.</p> <p>24 With respect to CVS and Aetna, since 2011 we 25 have been a party to a seven year agreement under which</p> <p>Page 24</p>
<p>1 aware, we are in active litigation with this group, and 2 this is not the appropriate forum to discuss that 3 litigation.</p> <p>4 However, I need to point out that Caremark 5 offers a range of network options to its clients, 6 including networks that allow patients to access HIV 7 drugs at local independent pharmacies.</p> <p>8 Our highest priority is assuring patient 9 access to clinically appropriate drugs while managing 10 overall healthcare costs for our clients, and we offer 11 our clients multiple clinical tools and pharmacy network 12 options targeted at achieving both of these goals. This 13 includes an option for clients to allow their members 14 with HIV to fill their HIV-related medications at 15 in-network local independent pharmacies and other 16 national chain retail pharmacies.</p> <p>17 Turning to the six specific questions. The 18 first question asked is, quote, "What will be the effect 19 of the proposed merger on competition in the California 20 health coverage market?" End quote.</p> <p>21 Competition within each of these segments in 22 which we operate, which are PBMs, pharmacies, and 23 insurers, is fierce and will remain so. The healthcare 24 sector will continue to attract significant investment 25 from companies entering and expanding. We believe</p> <p>Page 23</p>	<p>1 CVS provides PBM services to Aetna.</p> <p>2 The second question asked is, quote, "What 3 will be the effect of the proposed merger on consumer 4 premiums and out-of-pocket healthcare costs."</p> <p>5 Integrative pharmacy and medical information 6 will allow us to engage with the patient early and more 7 often and provide preventive care that can help avoid 8 the need for more serious and costly interventions.</p> <p>9 The combination of our pharmacy services with 10 Aetna's expertise and medical benefits will 11 significantly improve our ability to help patients 12 manage their chronic illnesses. Failures of care 13 coordination cost the healthcare system 35 billion 14 dollars per year.</p> <p>15 Similarly, there are some 60 billion in 16 savings in hyperlipidemia if patients were 95 percent 17 adherent to their medications. There are over 20 18 billion in avoidable healthcare costs in severe asthma.</p> <p>19 If we can even address a small portion of 20 failure of care in these populations, we will be able to 21 reduce healthcare costs for payers and consumers 22 significantly. Further, the combination will also allow 23 us to explore new benefits designs with zero copays or 24 reduced cost sharing. Cost savings from this 25 transaction will allow us to be even more competitive</p> <p>Page 25</p>

<p>1 with our peers, ultimately passing on additional savings 2 to consumers, including employers.</p> <p>3 We will pass along cost savings to our 4 consumers in two ways. First, as our costs go down, 5 consumers will see the benefits in terms of premiums 6 that will be lower than they would be otherwise.</p> <p>7 Second, we intend to invest these savings into 8 improving the quality of services we offer to consumers, 9 thus these cost savings will improve our consumers 10 experiences in ways beyond merely the cost of their 11 premiums.</p> <p>12 The third question asked is, quote, "What will 13 be the effect of the proposed merger on provider and 14 facility network, contracting, and on consumer choice of 15 and access to providers?" End quote.</p> <p>16 Importantly, Aetna plan members will continue 17 to be able to see their primary care physicians and fill 18 prescriptions at non CVS pharmacies as they do today.</p> <p>19 Our customers expect Aetna to provide access 20 to a diverse network of healthcare professionals and 21 pharmacies. Closing or severely restricting our network 22 would be bad for our business. We will ensure that our 23 incentives are aligned to provide the highest quality 24 plans, highest access, and greatest cost savings for our 25 beneficiaries. We do not plan to change to this.</p> <p>Page 26</p>	<p>1 and will continue to play in the future.</p> <p>2 Additionally, MinuteClinic currently has 3 affiliations with 70 health systems nationally, a 4 further indication of our commitment to the importance 5 of supporting the care management system prescribed by 6 the treating information.</p> <p>7 The fifth question is, quote, "What 8 efficiencies, if any, are expected from the proposed 9 merger and what are their implications for the cost and 10 quality of care delivered to consumers?" End quote.</p> <p>11 CVS Health projects that it will achieve 12 approximately \$750 million in annual recurring savings 13 shortly after closing this transaction. These near-term 14 benefits will include substantial savings in the form of 15 medical cost reductions from improved care management.</p> <p>16 Over the longer term, or within three-to-five 17 years, the transaction is expected to result in further 18 reduction in medical costs. One of the most significant 19 opportunities for obtaining those savings is through the 20 improved coordinated chronic care management that CVS 21 Health will be better able to integrate as a result of 22 the proposed transaction.</p> <p>23 Patients with at least one chronic condition, 24 such as diabetes, heart disease, or cancer, account for 25 more than 80 percent of all hospital admissions and more</p> <p>Page 28</p>
<p>1 The fourth question asked is, quote, "What 2 will be the effect of the proposed merger on network 3 design, including on the ability of consumers to 4 continue to receive care from their current providers on 5 an in-network basis?" End quote.</p> <p>6 At present we have no intention to make 7 changes in the plans provider network after the closing 8 date other than changes in the normal course of 9 business. Consumers are protected as any changes that 10 are contemplated in the future must comply with 11 California regulations and requirements.</p> <p>12 Post transaction, we will strengthen 13 relationships with providers. We want to fortify the 14 provider-patient relationship while making outcomes 15 better and more affordable.</p> <p>16 Aetna requires our Medicare members, and 17 encourages all members, to have a primary care 18 physician. We will continue to do that. About half of 19 the patients who come to MinuteClinic, as I mentioned, 20 do not currently have a primary care provider.</p> <p>21 MinuteClinic providers counsel patients about 22 the importance of having a primary care provider and 23 provides patients with a list of physicians in their 24 area. Connecting physicians and patients is an 25 important role MinuteClinic and CVS Health play today</p> <p>Page 27</p>	<p>1 than 90 percent of all prescriptions filled.</p> <p>2 The combined company will be able to better 3 manage medical costs for chronic patients by providing 4 them, first, better coordination of care across 5 providers, including physicians, and, two, post 6 discharge support to increase medication adherence and 7 reduce hospital readmissions. Three, increase patient 8 engagement at the pharmacy, at a walk-in clinic, or in 9 their home, to supplement physician office visits. And, 10 four, greater access to care through convenient, lower 11 cost sites of care.</p> <p>12 The expected improvement in health outcomes 13 and reduction in spending will benefit members and the 14 healthcare system overall.</p> <p>15 The shorter terms savings will also include 16 lower costs resulting from the combining of the 17 companies operations in the PBM and Medicare areas and 18 the streamlining of redundant corporate functions. 19 There will be no changes, however, to Aetna's licensed 20 insurance company operations at closing.</p> <p>21 The sixth and last question asked is, quote, 22 "What will be the competitive effects of a vertical 23 merger in the health insurance retail pharmacy and 24 pharmacy benefit manager PBM markets, including barriers 25 to entry by competitors, elimination of Aetna as a</p> <p>Page 29</p>



<p>1 potential PBM competitor, and effects on network and PBM 2 service contracting by competitors, on competitor PBM 3 data utilization, and on pharmaceutical costs borne by 4 insurance consumers.</p> <p>5 This is a complementary transaction, sir. Our 6 businesses and areas of expertise differ. Our 7 acquisition of Aetna does not further concentrate the 8 healthcare sector. Instead, it reconfigures it to bring 9 together disparate parts of the healthcare system that 10 today lead to ineffective and more costly care.</p> <p>11 The healthcare sector will not be losing a 12 pharmacy, health plan, or PBM, as I noted earlier.</p> <p>13 CVS Health services will continue to be fully 14 available to other health plans here in California, and 15 nationally. This includes PBM services and pharmacy 16 services. In fact 88-to-89 percent of CVS Health 17 revenue come from the services we provide to health 18 plans other than Aetna across this country.</p> <p>19 These continued revenues are critical for us 20 to maintain and a fundamental guiding principal for our 21 business going forward. We will continue to provide 22 services to other health plans, employers and unions, 23 and we will work with pharmacies across the country, 24 independents and chain, to build networks across 25 California and across the country. This has been CVS</p> <p>Page 30</p>	<p>1 businesses.</p> <p>2 In addition, health plans, including Aetna, 3 impose similar restrictions on Caremark as a condition 4 of doing business. Beyond our firewalls and (inaudible) 5 limitations, we also have a commercial imperative to 6 protect our consumers and suppliers' confidential 7 information. Failing to do so would risk loss of an 8 enormous amount of business for us.</p> <p>9 With respect to the effects of pharmaceutical 10 costs borne by insurance consumers, let me start by 11 saying first that drug prices are set by the 12 pharmaceutical manufacturers. We believe combining drug 13 and medical benefits in the same place will allow payers 14 to determine whether expensive new drugs are actually 15 making people better and saving money by keeping them 16 out of the hospital.</p> <p>17 This information will help reduce the use of 18 expensive drugs that are not resulting in better 19 outcomes, and contributing to lower overall healthcare 20 costs.</p> <p>21 At CVS Health, we work every day to lower the 22 price consumers pay for their medicines. For example, 23 we offer point of sale rebates to our clients, and 24 currently have 10 million lives that are enrolled in 25 these plans, which gives consumers the direct benefit of</p> <p>Page 32</p>
<p>1 Health's commitment in the past, and it will continue 2 going forward.</p> <p>3 For example, even those CVS Caremark health 4 plan clients offer Part D services that compete with 5 Silver Script, CVS Caremark has provided the highest 6 level of PBM services to those health plans. In fact, 7 we know from our experience with Silver Script, our 8 standalone Part D prescription drug plan, that we can 9 take innovations learned there, and offer them to our 10 other clients.</p> <p>11 That is why, for example, 83 percent of CVS 12 Caremark's Medicare Part D clients have star ratings of 13 four and five, and have seen significant improvements in 14 these ratings.</p> <p>15 That is the exact model we envision for the 16 combined company, and we will be offering our 17 innovations on an open platform.</p> <p>18 With respect to the effects on competitor PBM 19 data utilization, CVS Health currently operates with a 20 number of firewalls in place to ensure the proper use of 21 its customers' information. For example, Caremark has 22 long provided PBM services to Medicare Part D Plan 23 sponsors that compete with Silver Script, as I noted, 24 and we have sufficient and affective firewalls without 25 incident or complaint in the operation of those</p> <p>Page 31</p>	<p>1 the negotiated drug price.</p> <p>2 We also offer our clients plans, as we do to 3 our CVS Health employees, where maintenance medications, 4 including insulin and generic drugs, are provided at no 5 copay. Importantly, as I noted earlier, we are bringing 6 actual transparency to the physician's office and to the 7 pharmacy counter to help consumers choose lower cost 8 medications.</p> <p>9 That completes our answers to the six 10 questions and we look forward to answering questions 11 during the Q and A.</p> <p>12 But before I turn and close, we are pleased 13 that our proposed transaction is also supported by a 14 wide range of California providers including the 15 National Hispanic Medical Association, Memorial Care, 16 Cedar Sinai, and Venice Family Clinic, and community 17 leaders such as the mayor of Fresno and the California 18 Hispanic Chambers of Commerce.</p> <p>19 These organizations and many others have 20 provided testimony on our behalf at a prior hearing, and 21 several of them will be here sharing their views with 22 the Department. We are grateful for their support.</p> <p>23 In closing, we are confidential that our 24 acquisition of Aetna will enhance competition in the 25 healthcare marketplace by creating significant consumer</p> <p>Page 33</p>

<p>1 benefits and spurring innovation in an industry that 2 disparately needs it. By integrating medical and 3 pharmacy information and enhancing local services, the 4 merger will deliver significant value to California 5 consumers.</p> <p>6 Competition in the PBM industry is robust, and 7 will continue to be so after this merger. The merger 8 does not eliminate a competitor. Competition in the 9 pharmacy industry also continues to thrive. This is 10 especially true for independent pharmacies. Recognizing 11 the important role that these independent pharmacies 12 play in providing affordable pharmacy access to patients 13 here in California, independents comprise some 14 41 percent of our networks.</p> <p>15 Finally, competition in the Part D business 16 will continue to be healthy as well, with several 17 Fortune 500 competitors, including Anthem, Cigna, 18 Express Scripts, Humana, Rite Aid, United Health, and 19 Wealthcare.</p> <p>20 In the face of this competition, the 21 transaction will enable our companies to combine our 22 complementary expertise and lower our costs in order to 23 offer even more competitive Part D plans and Medicare 24 Advantage plans to seniors.</p> <p>25 We believe that integration in healthcare</p> <p>Page 34</p>	<p>1 for having us here this morning to talk about a proposed 2 transaction that Aetna is incredibly excited about.</p> <p>3 We see this as really the next and most 4 important step in Aetna's journey to put consumers at 5 the center of their own healthcare. On a somewhat 6 personal note, as someone who has spent her entire 7 career trying very hard to make improvements in a 8 healthcare system that is largely broken, much of that 9 work done right here in California, I see the proposed 10 coming together of CVS and Aetna as one of the most 11 promising developments in healthcare in a while.</p> <p>12 Aetna's a national company as you know, but 13 our roots here in California go deep. We have been here 14 for over a century, and as just one example, in the 1906 15 San Francisco earthquake, Aetna was there, we paid out 16 about 3 million in claims. Since that time we've 17 evolved from a life and accident coverage into a 18 healthcare company with a focus on medical coverage.</p> <p>19 Today in California we serve approximately 20 1.4 million medical members through various product and 21 funding arrangements. Or workforce here in California 22 is about 2600 associates, 1400 of whom work across nine 23 offices in the state, the other 1200 work from home. We 24 span the geography here in California with offices in 25 San Francisco, Sacramento, Walnut Creek. In southern</p> <p>Page 36</p>
<p>1 communities is one key aspect of solving rising 2 healthcare costs and reducing the complexity consumers 3 face in the current system. Adding a full range of 4 pharmacy, pharmacy benefit management, and MinuteClinic 5 services to an integrated health plan, goes beyond the 6 existing business models and will further transform 7 delivery of care.</p> <p>8 This transaction is about bringing two 9 complementary businesses to create an innovative, new 10 healthcare platform that is easy to use, less expensive 11 for consumers, and that partners with local healthcare 12 providers to deliver superior coordinated care. It's 13 about fulfilling an evolution of our vision and our 14 commitment to better health and healthcare.</p> <p>15 Thank you for the opportunity to speak with 16 you this morning, and you will hear next from Kristen 17 Miranda, who will share Aetna's perspective on the 18 benefits of the proposed transaction.</p> <p>19 Thank you again.</p> <p>20 COMMISSIONER JONES: Thank you, Mr. Moriarty.</p> <p>21 MS. MIRANDA: Great. Thank you, and good 22 morning.</p> <p>23 Just to reiterate, my name is Kristen Miranda, 24 I'm the California market president for Aetna. And I'd 25 like to echo Tom's appreciation to you, Commissioner,</p> <p>Page 35</p>	<p>1 California we go from San Diego go up to Orange County 2 to Los Angeles and Woodland Hills.</p> <p>3 In the central valley, I'm especially proud to 4 call out that we have a facility there that has about 5 1100 employees in the city of Fresno, which makes us one 6 of the largest private employers in that community.</p> <p>7 Fresno, as you probably know, is a city with an 8 unemployment rate of approximately 7.6 percent, almost 9 double the national average. It means something to us 10 at Aetna that we are embedded in that community and able 11 to give something back in terms of jobs and opportunity.</p> <p>12 I'm going to touch briefly on Aetna's products 13 both nationally and here in California. We currently 14 serve approximately 38 million people nationally, with 15 information and resources that help them make better 16 informed decisions about their healthcare. We offer a 17 broad range of traditional, voluntary, and consumer 18 directed health insurance products including medical, 19 pharmacy, dental, behavioral health, Medicaid, and 20 workers' comp options.</p> <p>21 Here in California, Aetna serves multiple 22 employer segments ranging from large multisite national 23 customers to 100-and-below small group employers. We're 24 fortunate to serve beneficiaries in the Medicare 25 Advantage market, and most recently, effective the</p> <p>Page 37</p>

<p>1 beginning of this year, Aetna entered both San Diego and 2 Sacramento counties for MediCal. We are thrilled to be 3 able to serve that vitally important market.</p> <p>4 As of March of this year, approximately 5 20 percent of Aetna's 1.4 million enrollees here in 6 California are in PPO fully insured commercial products, 7 which are, of course, regulated by the Department of 8 Insurance. About 18 percent are in HMO products that 9 are, of course, regulated by the DMHC, and the remaining 10 62 percent are in self-funded PPO products regulated by 11 the federal government.</p> <p>12 As Tom indicated, the status quo in healthcare 13 is not working. We have an incredibly fragmented, 14 siloed system that is much too expensive and much too 15 complicated to navigate through. This is true not just 16 across the country, but here in California as well.</p> <p>17 Today's healthcare system is largely designed 18 to fix people when they are broken, not keep them 19 healthy and active throughout their lives. It's focused 20 on delivering new clinical capabilities, but research 21 clearly now shows that a full 60 percent of the factors 22 leading to premature death have nothing to do with the 23 care that a patient receives in a physician's office, in 24 a hospital, or even related to their genetics.</p> <p>25 The 60 percent of factors that we can no</p> <p>Page 38</p>	<p>1 Our goal is to create a consumer centric 2 model. One that is embedded in the local community, 3 those that we jointly serve, and one that enables us to 4 learn more about the health needs and ambitions of the 5 individuals that we serve.</p> <p>6 This is not something that Aetna can do on its 7 own, but this transaction gives us the opportunity to 8 become a new front door to the healthcare system, 9 meeting patients where they are and engaging them. This 10 is why, from Aetna's perspective, the combination of our 11 two companies is so compelling.</p> <p>12 I want to spend a minute talking about the 13 incredibly important physician-patient relationship. As 14 a healthcare company, Aetna understands and deeply 15 respects the important primacy of that relationship. 16 Our new company certainly won't seek in any way to 17 diminish that, in fact quite the opposite. We actually 18 believe that the physician-patient connection will be 19 strengthened as our enrollees will have additional 20 resources to support their healthcare needs in their 21 local communities.</p> <p>22 As Tom noted, there are no proposed changes in 23 our provider contracts at this time, other than those 24 that would come up as just the normal course of 25 business. We would certainly discuss any proposed</p> <p>Page 40</p>
<p>1 longer ignore are the social and environmental factors 2 that are critical to overall wellbeing. The unfortunate 3 reality today is that your zip code has a direct and 4 often profound impact on your wellbeing and you health 5 status.</p> <p>6 The US News and World Report recently, in 7 partnership with Aetna's foundation, conducted a study 8 ranking the 500 healthiest communities in America. Many 9 communities here in California made the list, Marin 10 County, Placer, Santa Clara, just to name a couple.</p> <p>11 Unfortunately, these communities stand in 12 sharp contrast to other California counties that are 13 struggling with variable issues related to the social 14 determinants of health. So for us, the coming together of 15 CVS and Aetna represents a meaningful opportunity for 16 this combined company to make a significant difference 17 in this landscape, to improve the healthcare delivery 18 system at the most local level.</p> <p>19 Together CVS and Aetna will work to create an 20 improved healthcare experience for consumers, with 21 expanded access that meets consumers where and when they 22 need to be met. We plan to combine CVS' broad retail 23 footprint with Aetna's analytical capabilities, 24 predictive modeling tools, our extensive network of 25 physicians, hospitals, and other medical professionals.</p> <p>Page 39</p>	<p>1 future changes, as appropriate, with state regulators.</p> <p>2 Our provider partners are, in fact, central to 3 the work that we do at Aetna and to the value that we 4 bring our customers. This transactions will not affect 5 Aetna's networks or our network designs. We believe at 6 Aetna that strong collaborative relationships with 7 hospitals and physicians coupled with member engagement 8 capabilities are our keys to driving value to consumers 9 in California.</p> <p>10 Our national goal is to have 75 percent of our 11 provider reimbursements in value-based models by 2020, 12 and I'm proud that Aetna has played a significant 13 leadership role across the country and here in 14 California, in not only supporting but in driving that 15 important transformation.</p> <p>16 In California our ACO partnerships range from 17 Memorial Care, who serves customers of ours in Los 18 Angeles and Orange counties, to Providence Health, to 19 Prime Care in the Inland Empire, to Sharp Health in San 20 Diego.</p> <p>21 As you're aware, in northern California we 22 recently launched a joint venture with Sutter Health to 23 serve our PPO members. By bringing together the 24 clinical and medical management capabilities of these 25 sophisticated provider organizations, and coupling those</p> <p>Page 41</p>

<p>1 with what Aetna brings to the table in terms of robust 2 claims data, predictive modeling tools, and member 3 engagement capabilities, we are actively improving, we 4 believe, the health of California.</p> <p>5 We also remain focused on quality. As just 6 one example, Aetna contracts today in California with 81 7 highly regarded centers of excellence. These are 8 publically recognized provider organizations that 9 deliver highly complex and specialized services to Aetna 10 customers and of course will continue to do so.</p> <p>11 As important as quality and access are, cost, 12 and specifically the effect of this transaction on 13 consumer costs, is of critical importance. I'd like to 14 be very clear on this: As Tom noted, costs associated 15 with this merger will not be passed on to Aetna's 16 customers. They will not result in increased premiums, 17 increased co-pays, or increased deductibles.</p> <p>18 Just as important to Aetna, is our commitment 19 to diversity and corporate social responsibility. Those 20 are core business values of ours and an important 21 element of our culture. As just one example of this 22 commitment, Aetna has been for 10 years in a row ranked 23 by Diversity Inc. as one of the top 50 companies in the 24 country.</p> <p>25 We've taken specific actions to ensure that</p> <p>Page 42</p>	<p>1 come from retail pharmacy and pharmacy benefits 2 management. Aetna is focused on health insurance and 3 does not have a retail footprint in any of the 4 communities that we serve.</p> <p>5 Thus the Aetna and CVS transaction brings 6 together two innovative businesses in a sector that is 7 very much in need of change. The new company will offer 8 a local experience that is simpler to use and built 9 around consumers.</p> <p>10 And with that I would just like to say, again, 11 thank you very much for having us with you today. We 12 look forward to questions.</p> <p>13 COMMISSIONER JONES: Thank you very much, and 14 I appreciate your testimony as well as Mr. Moriarty's 15 testimony.</p> <p>16 I want to go back to something Mr. Moriarty 17 said, which was that, I believe, CVS and Aetna have 18 quantified the potential savings of the merger at an 19 annual figure. I think the figure was, if I had it 20 correct, \$750 million a year?</p> <p>21 MR. MORIARTY: That's correct sir, yes.</p> <p>22 COMMISSIONER JONES: And did I understand your 23 testimony to be also that that is what CVS and Aetna 24 anticipate, by way of savings, annually for a five-year 25 period?</p> <p>Page 44</p>
<p>1 diversity is integrated in to all aspects of how we do 2 business, including diversifying our supplier base to 3 strengthen our ability to do business with suppliers who 4 represent the cultures and the geographies that we 5 serve.</p> <p>6 Aetna has had a long commitment to our LGBT 7 employees and to the LGBT community at large, from being 8 one of the first companies implementing policies for 9 domestic partners to being the first major health 10 benefits company to often transgender inclusive benefits 11 to our own employees.</p> <p>12 Lastly, Aetna has made a significant 13 commitment to improving the health and wellbeing of 14 Californians through our foundation, through corporate 15 giving, and through employee volunteerism. Since 2010, 16 Aetna has contributed over 7.4 million in California to 17 make improvements in health through community grants and 18 partnerships. In addition, in just the last two years, 19 Aetna employees here in California have volunteered over 20 60,000 hours to causes that are important to them and to 21 us.</p> <p>22 I'd like to end by noting that Commissioner, 23 as you mentioned in the beginning, this is a vertical 24 transaction with no significant overlap in the two 25 existing businesses. The vast majority of CVS' revenues</p> <p>Page 43</p>	<p>1 MR. MORIARTY: We view the 750 that I 2 specified as recurring, so that's both through reduced 3 medical costs and enhanced operational efficiencies as 4 part of the transaction.</p> <p>5 COMMISSIONER JONES: What's the duration of 6 time that you anticipate that annual savings to accrue 7 to the merged entity?</p> <p>8 MR. MORIARTY: We stated publically, sir, that 9 we anticipate that those synergies will be achieved over 10 the first two years after closing.</p> <p>11 COMMISSIONER JONES: And how long will they 12 continue?</p> <p>13 MR. MORIARTY: They, again, will be recurring, 14 so they will be part of the business as we move forward. 15 And our goal is to continue to look to improve, and as 16 we talked about, look at where some of the key costs are 17 in medical costs, some of the key conditions, diabetes, 18 asthma etcetera, and look for greater ways to manage 19 those and lead to even more cost savings.</p> <p>20 COMMISSIONER JONES: So there's no endpoint in 21 your respective company's analysis with regard to the 22 \$750 million in annual savings?</p> <p>23 MR. MORIARTY: Well, it is -- once achieved, 24 it becomes recurring in the sense that it's been 25 achieved and it's represented as you go forward.</p> <p>Page 45</p>

<p>1 It's not a new 750 each year, if that's, I 2 think, what you may be asking.</p> <p>3 COMMISSIONER JONES: Well, I guess I'm trying 4 to understand. So the notion is within the first two 5 years you'll have \$750 million in savings, and then each 6 year thereafter those savings will continue to accrue. 7 It's not an additional 750 on top of every 750 every 8 year, but rather that \$750 million in annual savings 9 will be the savings that the merged companies anticipate 10 they will be benefiting from on an ongoing basis from 11 year two forward?</p> <p>12 MR. MORIARTY: That's correct.</p> <p>13 COMMISSIONER JONES: Then I think you also 14 testified, as you did just a moment ago in response to 15 my question, that there are some other potentials for 16 savings beyond that associated with integrated care 17 management, I think you said, better coordination of 18 care, decreased hospital admissions, increased patient 19 engagement, increased access to care. There were a 20 variety of things you listed.</p> <p>21 So do I understand your testimony to be that 22 on top of the \$750 million a year in savings, the merged 23 entities anticipate additional savings?</p> <p>24 MR. MORIARTY: That's correct, sir. As we 25 bring these organizations together and, again, we look</p> <p>Page 46</p>	<p>1 opening remarks, roughly in a three-to-five year 2 timeframe.</p> <p>3 COMMISSIONER JONES: And then has there been 4 any quantification with regard to this additional 5 increment of savings that the companies or the merged 6 entity anticipates?</p> <p>7 MR. MORIARTY: We have -- "we" being CVS 8 Health -- do not have any quantification for that.</p> <p>9 Aetna has identified, I believe in their S4, a 10 figure that they feel is potentially achievable, just as 11 a way of demonstrating the value that the transaction 12 can bring.</p> <p>13 COMMISSIONER JONES: So let me turn to Aetna, 14 then, and see if you can share with me the figure that 15 Aetna believes might accrue as a result of these 16 additional savings in the out years.</p> <p>17 MR. WINGLE: We can up supply that figure to 18 you, Commissioner, after the hearing.</p> <p>19 COMMISSIONER JONES: Is it known to you now?</p> <p>20 MR. WINGLE: Not off the top of my head. I 21 need to refer to the file.</p> <p>22 COMMISSIONER JONES: That would be great if 23 you could.</p> <p>24 Is there anything else that Aetna could share 25 with us to elaborate on that particular additional</p> <p>Page 48</p>
<p>1 at where the higher cost areas are in terms of some of 2 the key chronic and complex conditions, we think that by 3 bringing the companies together, the better use of the 4 care coordination and management tools that Aetna 5 brings, as well as our local presence, our ability to 6 integrate and work with patients much more directly and 7 on an continual basis, that we can start solving for 8 that.</p> <p>9 And again, any just small increase in 10 adherence in some of these key chronic and complex 11 conditions, lead to significant reduction in costs that 12 will inure to the benefit of the citizens of California 13 as well as nationally.</p> <p>14 COMMISSIONER JONES: Do either of you have a 15 start date for those additional savings on top of the 16 \$750 million a year?</p> <p>17 MR. MORIARTY: It's part of our integration 18 planning as we start, and then obviously as soon as we 19 close the transaction, it will be a very key focus for 20 us as we go forward to drive innovative, new solutions 21 in some of these areas.</p> <p>22 COMMISSIONER JONES: What does your plan say 23 with regard to when you anticipate those savings might 24 accrue?</p> <p>25 MR. MORIARTY: As I think I indicated in my</p> <p>Page 47</p>	<p>1 dollar figure of savings? Is there any analysis or 2 indication with regard to how long that might accrue? 3 Is it an annual savings? Anything else that you could 4 elaborate on that?</p> <p>5 MR. WINGLE: I think we're aligned around the 6 timeframe. Obviously we're focused on 7 condition-specific interventions that would provide the 8 best value both to our consumers but also in terms of 9 achieving the targets.</p> <p>10 COMMISSIONER JONES: Okay. But you'll provide 11 us with the figure and any -- do you have any 12 information with regard to the duration of time that 13 that additional savings will accrue?</p> <p>14 MR. WINGLE: Well, we hope that the 15 improvements are ongoing and become foundational, 16 obviously. So, you know, obviously each new initiative 17 would be additive, so we would hope that continuous 18 improvement would be an ongoing focus of the company.</p> <p>19 COMMISSIONER JONES: Okay. Then let me ask 20 both companies: With regard to the \$750 million a year 21 in savings, where will that savings go?</p> <p>22 Let's start with CVS.</p> <p>23 MR. MORIARTY: I can start, and then obviously 24 I'd ask my colleagues from Aetna.</p> <p>25 We don't have a specific in terms of where it</p> <p>Page 49</p>

<p>1 will flow directly to beneficiaries. Obviously, as we 2 can reduce medical costs and reduction in medical 3 costs -- and condition-specific cost is a key component 4 of that 750 -- that should enure to the benefit of the 5 consumers here in California as well as nationally, as I 6 stated earlier.</p> <p>7 COMMISSIONER JONES: Do you want to add 8 anything?</p> <p>9 MS. MIRANDA: Yeah, I think that really 10 captures it. I think the intent certainly is that the 11 efficiencies that will be driving will go to, you know, 12 invest in programs that improve health.</p> <p>13 COMMISSIONER JONES: So back to Mr. Moriarty, 14 nothing specific, but a general statement of where the 15 savings go.</p> <p>16 Let me ask specifically, will the entirety of 17 the \$750 million be allocated to reductions in premium 18 or decreases in the rate of increase of premium for the 19 merged entity?</p> <p>20 MR. MORIARTY: I can't say, Commissioner, what 21 percentage will. There certainly will be some. There 22 obviously are investments that need to be made in 23 systems and other programs to drive these longer term, 24 and so you'll see a component of that reinvested in to 25 the business as well to improve the services and develop</p> <p>Page 50</p>	<p>1 allocation of \$750 million to either reduce premium or 2 to decrease the increase in premium over time?</p> <p>3 MR. MORIARTY: I don't as I sit here today, 4 Commissioner, but if we have done that, we will provide 5 it.</p> <p>6 COMMISSIONER JONES: I appreciate that. 7 Let me go now to some of the specifics that 8 you testified about with regard to the merger.</p> <p>9 Both companies have testified that there will 10 be no competitive impacts on any of the various markets 11 in which you variously operate, whether it's retail 12 pharmacy, PBM, insurance, Part D Medicare drug plans.</p> <p>13 So is that correct, it's your, CVS' view that 14 there will be no negative competitive effects in any of 15 those markets?</p> <p>16 MR. MORIARTY: That's correct.</p> <p>17 COMMISSIONER JONES: Is that Aetna's view as 18 well?</p> <p>19 MS. MIRANDA: It is.</p> <p>20 COMMISSIONER JONES: So one of the things you 21 have also testified to, if I understand correctly, is 22 that CVS, in particular CareMark, its PBM entity, will 23 continue to contract with a variety of different 24 entities including those that might be competitors of 25 Aetna.</p> <p>Page 52</p>
<p>1 better programs as we go forward.</p> <p>2 COMMISSIONER JONES: Aetna, can you give me a 3 specific answer to the question of whether or what 4 amount of the \$750 million will result in a reduction in 5 premium?</p> <p>6 MR. WINGLE: Not on an allocated basis. I'd 7 say that we are interested in reducing premium pressure. 8 Obviously there are larger factors driving medical costs 9 in the system, but we would like to, you know, put this 10 against any of those costs and those cost pressures. 11 But we also want to improve the quality of our services 12 as well. So we believe that under both circumstances 13 the consumer will benefit.</p> <p>14 COMMISSIONER JONES: Can Aetna give me any 15 estimate of the portion of the \$750 million a year that 16 will be allocated to premium reductions or decreases in 17 the increase in premium?</p> <p>18 MR. WINGLE: I don't have that information 19 available at this time.</p> <p>20 COMMISSIONER JONES: Has there been an 21 estimate made by the company?</p> <p>22 MR. WINGLE: Not that I'm aware of, but we can 23 get back to you on that.</p> <p>24 COMMISSIONER JONES: I appreciate that. 25 CVS, do you have any estimate of the</p> <p>Page 51</p>	<p>1 Is that correct?</p> <p>2 MR. MORIARTY: As we do today sir, yes.</p> <p>3 COMMISSIONER JONES: Okay. And you are doing 4 that today, but you're not, you're not merged today. So 5 I'm wondering how it is that the merger won't result in 6 incentives for CVS to give preferential treatment to 7 Aetna or providers in the Aetna network versus other 8 competitors of Aetna?</p> <p>9 MR. MORIARTY: Well, we have seven-plus years 10 or so of experience as being a service provider to Aetna 11 today in terms of how we have operated our business, 12 ensuring that we offer what we can to all of our clients 13 to ensure that we're lower in cost and improving the 14 service to them.</p> <p>15 So we have that market experience, as well as, 16 as I indicated, if you look at where the lion's share of 17 our revenues come today at CVS Health, 88 to 89 percent 18 come from other health plans. And it's our fundamental 19 goal that we continue that and we drive improvements 20 more broadly beyond simply Aetna, but in to the 21 healthcare system overall.</p> <p>22 COMMISSIONER JONES: Will there be any 23 differences in CareMark's business practices with non 24 Aetna insurers?</p> <p>25 MR. MORIARTY: Coming from the merger?</p> <p>Page 53</p>

<p>1 Absolutely not, no.</p> <p>2 COMMISSIONER JONES: Do you want to add</p> <p>3 something, Counsel?</p> <p>4 MS. FERGUSON: I did want to add something.</p> <p>5 What I wanted to add is today we do provide services to</p> <p>6 competitors, Silver Script, which is our Part D plan, is</p> <p>7 serviced by CareMark. CareMark also services other Part</p> <p>8 D plans. So today we are actually are providing</p> <p>9 services to direct competitors.</p> <p>10 COMMISSIONER JONES: So I heard that point in</p> <p>11 the testimony, and I heard the point that you have just</p> <p>12 reiterated, that there won't be any differences in</p> <p>13 CareMark's business practices with non Aetna insurers as</p> <p>14 a result of the merger.</p> <p>15 I just want to explore that a little bit. I</p> <p>16 understand the point you made in the testimony, which</p> <p>17 was that CareMark will continue to have and seek</p> <p>18 contracts with competitors of Aetna.</p> <p>19 What I'm wondering is whether there will be</p> <p>20 any pricing difference associated with the PBM services</p> <p>21 that CareMark provides to Aetna versus to other</p> <p>22 entities.</p> <p>23 MR. MORIARTY: Right. And what I can say,</p> <p>24 Commissioner, is that the PBM marketplace is highly</p> <p>25 competitive. If you look at the bids and the bid</p> <p>Page 54</p>	<p>1 COMMISSIONER JONES: Existing contracts. But</p> <p>2 those contracts aren't infinite in duration. They come</p> <p>3 to an end at some point, right?</p> <p>4 MR. MORIARTY: Some of them are very long in</p> <p>5 term.</p> <p>6 COMMISSIONER JONES: They seem like they're</p> <p>7 infinite to you.</p> <p>8 MR. MORIARTY: I want the record to be clear,</p> <p>9 I did not say that.</p> <p>10 COMMISSIONER JONES: I know. I know.</p> <p>11 MS. FERGUSON: He thought it, but he didn't</p> <p>12 say.</p> <p>13 COMMISSIONER JONES: You haven't tried the</p> <p>14 tea, either, but I'm trying. I'm trying.</p> <p>15 I understand. But just to be clear for the</p> <p>16 purpose of the record, the contracts have a finite</p> <p>17 period of time in which they are in operation, correct?</p> <p>18 MS. FERGUSON: Yes, they do.</p> <p>19 COMMISSIONER JONES: And then after that, that</p> <p>20 contract might being extended or it might not be</p> <p>21 extended. It might be renegotiated at different price</p> <p>22 term potentially, yes?</p> <p>23 MR. MORIARTY: Yes. But, again, as you look</p> <p>24 at the marketplace, those pricing trends have been very</p> <p>25 negative in terms of lowering costs in the sense of</p> <p>Page 56</p>
<p>1 structures and how they are done and how competitive</p> <p>2 those are, there will not be an ability to have a price</p> <p>3 difference between them. So our fundamental guiding</p> <p>4 principle, again, is to be as competitive as possible</p> <p>5 across our entire book of business.</p> <p>6 COMMISSIONER JONES: So you would rely on the</p> <p>7 market to discipline CareMark to make sure that it does</p> <p>8 not offer preferential pricing treatment to Aetna versus</p> <p>9 Aetna's competitors?</p> <p>10 MR. MORIARTY: It is an incredibly efficient</p> <p>11 marketplace in doing that, sir.</p> <p>12 COMMISSIONER JONES: Are there any other</p> <p>13 guarantees you can offer or commitments or is</p> <p>14 assurances, beyond the market, with regard to making</p> <p>15 sure that there aren't price differentials associated</p> <p>16 with your offering of PBM services to Aetna versus</p> <p>17 Aetna's competitors?</p> <p>18 MS. FERGUSON: We would have contractual</p> <p>19 commitments with our clients today that would prevent us</p> <p>20 from increasing prices.</p> <p>21 COMMISSIONER JONES: But those contracts are</p> <p>22 for a duration, a period of time, correct?</p> <p>23 MS. FERGUSON: They are, but we are always</p> <p>24 seeking to extend those. I'm just saying it's not just</p> <p>25 market pressures, we have client commitments as well.</p> <p>Page 55</p>	<p>1 driving further efficiencies into the system.</p> <p>2 COMMISSIONER JONES: The concern that I have,</p> <p>3 though, is that arguably the market for PBM services is</p> <p>4 getting smaller, not larger, and so I don't know -- I</p> <p>5 guess we'll here some testimony on this as well as to</p> <p>6 how competitive that market true is -- but if your</p> <p>7 answer is that the market will discipline CareMark, I</p> <p>8 think that's possible, but I'm trying to see if there's</p> <p>9 any other assurance or commitment that you're making as</p> <p>10 a part of this transaction that if the market doesn't</p> <p>11 discipline CareMark, there's some other form of</p> <p>12 commitment that CareMark won't engage in price</p> <p>13 differentials or price differentiation between Aetna and</p> <p>14 its competitors.</p> <p>15 MR. MORIARTY: I think there's several things</p> <p>16 to note and point out particularly in regard to what may</p> <p>17 be testimony later here, is how competitive the PBM</p> <p>18 marketplace is and how the barriers to entry are</p> <p>19 incredibly low. So I think the announcement by Anthem</p> <p>20 in terms of it wanting to bring in and bringing its own</p> <p>21 new PBM solutions marketplace is a great example of new</p> <p>22 competition coming in.</p> <p>23 There are any number of players here in</p> <p>24 California as well who remain. I noted five or six of</p> <p>25 them in my testimony, there are many more than that.</p> <p>Page 57</p>

<p>1 We obviously have our ongoing contractual</p> <p>2 commitments that we've talked about here in terms of</p> <p>3 providing the best price to the clients.</p> <p>4 I would also point out just simply the</p> <p>5 economic reality of our business and the need for</p> <p>6 CareMark to remain competitive to win and continue to</p> <p>7 grow as a very key factor in driving efficiency further</p> <p>8 into the system.</p> <p>9 COMMISSIONER JONES: So can you elaborate a</p> <p>10 little bit on CVS CareMark's business model? How does</p> <p>11 it make its money?</p> <p>12 MR. MORIARTY: At a very high level, the</p> <p>13 pharmacy benefit management model aggregates lives,</p> <p>14 aggregates shares, and drives discounting through</p> <p>15 negotiating to get to the deepest discounts across the</p> <p>16 board to lower costs.</p> <p>17 And if you look -- at we publish a drug trend</p> <p>18 report each year for CareMark, that looks at the price</p> <p>19 discounting and our ability to drive lowest costs for</p> <p>20 our clients. And while you'll see list pricing going up</p> <p>21 historically at double-digit levels, over the last</p> <p>22 several years we have seen low CIGLE (phonetic,) and in</p> <p>23 fact this year, almost less than 1 percent increase in</p> <p>24 the annual cost for our clients, and roughly a little</p> <p>25 more than a third actually had what's called negative</p> <p>Page 58</p>	<p>1 our ability to control costs for our clients increasing.</p> <p>2 COMMISSIONER JONES: On an annualized basis,</p> <p>3 what is the value of that rebate that is retained by CVS</p> <p>4 CareMark?</p> <p>5 MR. MORIARTY: I don't have that figure as I</p> <p>6 sit here today, sir.</p> <p>7 COMMISSIONER JONES: Do you have you it,</p> <p>8 Counsel?</p> <p>9 MS. FERGUSON: I don't.</p> <p>10 COMMISSIONER JONES: Could you provide it to</p> <p>11 us?</p> <p>12 MR. MORIARTY: I could review it and give you</p> <p>13 the information that we can give you, yes, sir.</p> <p>14 COMMISSIONER JONES: Okay. Thank you.</p> <p>15 Does CVS CareMark or CVS more broadly have any</p> <p>16 involvement with Anthem's new -- is IngenioRX PBM?</p> <p>17 MR. MORIARTY: Yes, sir. There was a</p> <p>18 competitive bid process to be the initial service</p> <p>19 provider to Anthem, and we were successful in that</p> <p>20 competitive process to win that. So we by and large</p> <p>21 will provide administrative services as Anthem launches</p> <p>22 their new PBM model.</p> <p>23 Importantly though, as Anthem has announced,</p> <p>24 they retain all the significant levels of controls</p> <p>25 associated with some of the key elements of the pharmacy</p> <p>Page 60</p>
<p>1 drug trends, where the cost from 2016 to 2017 was less.</p> <p>2 So those efficiencies, I think, are</p> <p>3 demonstrated by the data.</p> <p>4 COMMISSIONER JONES: So CVS CareMark</p> <p>5 negotiates with the drug manufacturers for a price, and</p> <p>6 uses its bargaining position as an aggregator of</p> <p>7 purchase, if you will, with all of the entities with</p> <p>8 whom you have contracts behind you.</p> <p>9 Does CVS CareMark pass through any rebates</p> <p>10 that it obtains one for one, any rebates it obtains from</p> <p>11 the drug manufacturer, do you pass 100 percent of that</p> <p>12 through to the payer or the consumer?</p> <p>13 MR. MORIARTY: Let me answer, first, by</p> <p>14 starting with what a rebate is.</p> <p>15 A rebate is essentially a price discount</p> <p>16 that's negotiated in terms of what the list price is</p> <p>17 versus what the net price will be associated with that.</p> <p>18 We pass more than 95 percent of rebates back.</p> <p>19 We actually have a number of clients where we pass</p> <p>20 100 percent back and they pay us an administrative fee.</p> <p>21 There are clients who actually do not want to do it that</p> <p>22 way, so we retain a certain portion of rebates in lieu</p> <p>23 of an administrative fee to pay for our services.</p> <p>24 And so what you have seen over the years is</p> <p>25 the rebating value, the discounting value increasing,</p> <p>Page 59</p>	<p>1 benefit management services that are part of that in</p> <p>2 conjunction with what we can offer.</p> <p>3 COMMISSIONER JONES: What happens to that</p> <p>4 relationship with Anthem and IngenioRX PBM post merger</p> <p>5 with Aetna?</p> <p>6 MR. MORIARTY: That will continue.</p> <p>7 COMMISSIONER JONES: Okay.</p> <p>8 Question for Aetna. So Aetna is obviously</p> <p>9 concerned, as you testified, about the rising cost of</p> <p>10 drugs, and Aetna has an economic interest in trying to</p> <p>11 obtain lower drug costs. We have heard from CVS that a</p> <p>12 portion of their business model is retaining a portion</p> <p>13 of the discount, if you will.</p> <p>14 So if Aetna is successful in driving drug</p> <p>15 costs down, that has an economic consequence for</p> <p>16 CareMark potentially. How exactly is that going to</p> <p>17 work? I mean isn't Aetna, in fact, no longer going to</p> <p>18 be as incentivized to reduce drug costs because the</p> <p>19 parent company's business model relies in part on</p> <p>20 retention of a portion of discounts that it's obtaining?</p> <p>21 So to the extent that the overall price goes</p> <p>22 down, less money to CareMark, not good for CareMark, may</p> <p>23 be good for Aetna.</p> <p>24 So how exactly is that going to work?</p> <p>25 MR. WINGLE: Well, what it does is it</p> <p>Page 61</p>



<p>1 completely aligns or interests together around the best 2 solution for the customer. So right now if it's an 3 over-the-fence transaction, one side's cost is another 4 side's revenue, we don't get that whole patient view. 5 If we can, together, figure out the best care 6 plan, the medical side and the pharmacy side, we hope 7 those efficiencies for the benefit of the entire 8 combined company, and more importantly to our members by 9 reducing some of their episodes of care and keeping them 10 adherent and compliant. 11 As you know, drug costs are a significant 12 concern in the healthcare system. They currently 13 represent about 20 percent of our healthcare spend, and 14 you know, specialty drugs, which are only 1.3 percent of 15 our scripts, represent 40 percent of our pharmacy costs. 16 So we are interested in addressing the 17 challenge of drug costs, and believe that when we marry 18 the medical and the pharmacy view together, we'll get 19 that stronger alignment that we need to address the 20 problem. 21 MS. MIRANDA: You know, I think Paul's point 22 is an important one. It might also be worth just noting 23 that in California, Aetna today has 5000 retail pharmacy 24 options for our members that are non CVS. We have about 25 1100 pharmacies in our network in California that are</p> <p>Page 62</p>	<p>1 while the CVS pharmacies, the MinuteClinics are in 2 network? 3 MS. MIRANDA: Yeah, no plans like that all, 4 Commissioner. 5 COMMISSIONER JONES: So there won't be any 6 steering of Aetna patients towards the one-minute 7 clinics? 8 MS. MIRANDA: Well, again, we have 9 significant -- now we're talking about the 10 MinuteClinics -- we have a significant number of other 11 kinds of retail settings and urgent care clinics and 12 things like that. So we have no plans to change the 13 composition of that network, and no plans today to 14 change benefit designs to result in steerage into CVS. 15 COMMISSIONER JONES: Is there anything that 16 would prohibit you from doing that though? 17 MS. MIRANDA: Well, I think one thing -- 18 COMMISSIONER JONES: Other than network 19 adequacy, which we'll stipulate is always an issue. 20 It's out there, both regulators -- but assuming you 21 could meet network adequacy requirements under 22 California law and California regulation, whether it's 23 CDI or DMHC, and still at some point in the future put 24 the MinuteClinics or other CVS pharmacies in network and 25 the independents out of network, is there any commitment</p> <p>Page 64</p>
<p>1 CVS, right? Our members will absolutely continue to 2 have access to those non CVS pharmacies, right? It's 3 important for access, to ensure that we have coverage 4 across what is a very broad state, as you know. 5 It's also important because our customers 6 expect a reasonable degree of choice when they are 7 coming to us and purchasing products. 8 So I guess I'm just raising that as a bit of a 9 corollary. Certainly we do think that the integration 10 of pharmacy and medical will offer up some opportunities 11 that we really don't have today to better manage care 12 and cost, but in California we certainly will continue 13 to have a significant number of non CVS pharmacies 14 available to our customers. 15 COMMISSIONER JONES: Will the cost sharing be 16 the same for the non CVS pharmacies as for the CVS 17 pharmacies post merger? 18 MS. MIRANDA: I can tell you we certainly 19 don't have any plans to modify cost sharing for CVS 20 versus non CVS retail pharmacies. 21 Again, I think what is important to our 22 customers in California is that they continue to have a 23 degree of choice. 24 COMMISSIONER JONES: What about the potential 25 for having the independent pharmacies be out of network</p> <p>Page 63</p>	<p>1 as a part of this merger that would prohibit you from 2 doing that? 3 MS. MIRANDA: Well, I think again, in addition 4 to access, it would be that we have customers who expect 5 to have that degree of coverage in California. 6 Were you going to add something, Paul? 7 MR. WINGLE: No -- we'd be saying goodbye to a 8 significant chunk of our core business, which is part of 9 our value in this acquisition. 10 COMMISSIONER JONES: So let me go back to the 11 pricing question though, again. And that is: I'm still 12 not convinced that there isn't misalignment here of 13 incentives, if you will. 14 I understand your point about all of the 15 things you hope to do in terms of overall cost 16 reduction -- which I guess add in to this \$750 million a 17 year figure, and then some other figure in later out 18 years -- but on the issue of drug prices, which is what 19 I'm asking about now specifically, it seems to me that 20 Aetna's economic interest is trying to get those drug 21 prices down. CareMark's interest is somewhat mixed, 22 yes, getting it down, but they retain a portion of 23 whatever discount that they are able to negotiate. 24 So it just seems like those two interests 25 might be at odds with one another.</p> <p>Page 65</p>

<p>1 MR. WINGLE: I think I differ in that we are, 2 as a medical insurance company, very concerned about 3 drug adherence and making sure that the patients are 4 following the care plan. 5 One of the exciting things about this 6 opportunity is that we would be able to leverage the 7 significant network of pharmacists and retail sites to 8 reinforce the doctor's instructions around drug 9 adherence and keeping those prescriptions filled where 10 appropriate. 11 The point is to get to efficiency in the 12 system by looking at the efficacy. So if we see data 13 and we see results on the medical side that we can share 14 with the pharmacy side and say we're seeing some 15 inefficiencies here, how do we get to the patient and 16 get them the right solution? The drugs that are 17 prescribed, how do we work together to talk to the 18 provider community, to talk to that person's PCP or 19 their primary care provider, you know, how do we work to 20 get that patient from presenting in an urgent or 21 emergent condition, keep them healthy, whether that's 22 medical care or drug adherence. 23 COMMISSIONER JONES: So another question I 24 have is the issue of making sure people have access to 25 their primary care physician, and I think both of your</p> <p>Page 66</p>	<p>1 opportunity here is an increased adherence. And the 2 categories that I mentioned in my testimony of diabetes, 3 hyperlipidemia, cardiovascular, other areas where you 4 have lack of compliance today with the care plan and the 5 pharmacy plan the physician has prescribed for the 6 patient. 7 Those are your most significant opportunities 8 because each one-point increase in adherence to those 9 key chronic medications has a significant cost savings 10 for the health system and obviously has a huge impact on 11 the member health and quality of life for that. 12 So while there will be savings associated with 13 emergency room visits that can be taken care of at 14 MinuteClinic -- and we've seen that, frankly, in our own 15 CVS employee population, the study that I mentioned -- 16 the lion's share, and the most significant is chronic 17 care management, and better adherence to the physician 18 care management plan. 19 COMMISSIONER JONES: Does Aetna want to add 20 anything on that? 21 MS. MIRANDA: Yeah, you know, I think really 22 all that I would add is this is certainly not about 23 supplanting that critical primary care physician 24 relationship with his or her patient. We actually, even 25 in products that we have today that don't require that</p> <p>Page 68</p>
<p>1 companies testimonies are that the MinuteClinics are 2 actually a channel, have been a channel for acquainting 3 people with a primary care physician who don't currently 4 have one. 5 If I understand correctly, tell me if I'm 6 wrong, that you believe that this merger will increase 7 access to primary care physicians as opposed to today 8 decrease it? 9 MR. MORIARTY: That's correct. 10 COMMISSIONER JONES: Is that Aetna's view as 11 well? 12 MS. MIRANDA: Yes, absolutely. 13 COMMISSIONER JONES: So I think there's a 14 little bit of a conflict here, though, between the 15 testimony about the savings, which in part, if I 16 understand the testimony correctly, involves the 17 utilization of the pharmacies and within the pharmacies 18 they have MinuteClinics, the MinuteClinics has a more 19 robust provider of primary care services, and this 20 testimony about not reducing access to a primary care 21 physician. 22 So which is it? 23 MR. MORIARTY: I'll start and the colleagues 24 can add to it. 25 The most significant part of the savings</p> <p>Page 67</p>	<p>1 assignment, we really do try to encourage it where we 2 can. 3 The other thing that I would note is that in 4 addition to 50 percent of the folks who access 5 MinuteClinics not even having an established primary 6 care physician today, the opportunity that we have to 7 connect them with a primary care in their community 8 who's accepting patients, 50 percent of those who visit 9 a MinuteClinic are doing so after hours where their 10 primary care physician is not accessible. 11 COMMISSIONER JONES: So why can't these 12 benefits associated with greater adherence to drug 13 regimes or courses of treatment or greater access to the 14 MinuteClinics to primary care physicians, why can't that 15 be accomplished through a contract between Aetna and 16 CVS? Why is it necessary to merge the entities to 17 accomplish this? 18 I'll ask Aetna. 19 MR. WINGLE: The exciting thing for us is we 20 are trying to move away from the model of being the 21 warranty card that you pull out of your wallet when you 22 have a problem. I'm broken, I'm sick, I present my card 23 to get that fixed. The presentation at an emergency 24 room, the presentation at a doctor's office, is often 25 the lagging indicator of an issue or a problem.</p> <p>Page 69</p>

<p>1 We want to help and we want to join members to</p> <p>2 keep them healthy and maintain their health aspirations</p> <p>3 so they use the system as appropriate when they need to,</p> <p>4 but we're taking all the steps with them to make sure</p> <p>5 they're staying healthy.</p> <p>6 We cannot replicate on our own what CVS has.</p> <p>7 82 percent of the American public lives within ten miles</p> <p>8 of a CVS. 71 percent lives within five miles of a CVS.</p> <p>9 We're starting to pilot community based models of care</p> <p>10 in a couple of markets, and we're seeing great early</p> <p>11 success with that.</p> <p>12 We're partnering with social workers. We're</p> <p>13 partnering with visiting nurses. We're partnering with</p> <p>14 in-home meal delivery. We need a health hub in the</p> <p>15 community to expand that model. That's the model we</p> <p>16 want to use to address the social determinants, because</p> <p>17 as Kristen said, most of what drives health problems</p> <p>18 that we see are based on broader needs that you can only</p> <p>19 know by being local and getting to know folks in the</p> <p>20 community and being a hub for coordination in the</p> <p>21 community.</p> <p>22 And that's what the CVS presence gives us that</p> <p>23 we can't do on our own.</p> <p>24 COMMISSIONER JONES: But why can't you</p> <p>25 contract for that presence?</p> <p>Page 70</p>	<p>1 Align incentives, align organizations in a way</p> <p>2 where it's not a binary determination, but investments</p> <p>3 can be made more holistically and information systems</p> <p>4 can connect and we can drive better coordination between</p> <p>5 the physician, the pharmacy, and the caregivers in each</p> <p>6 community in which that patient is sitting.</p> <p>7 That's ultimately what we're go to be seeking</p> <p>8 to solve.</p> <p>9 COMMISSIONER JONES: I think it's your</p> <p>10 testimony that Aetna is not going to have any special</p> <p>11 deal with the PBM, it's not going to -- the information</p> <p>12 that the PBM collects from other payers is not going to</p> <p>13 be shared with Aetna, and the PBM is not going to use</p> <p>14 its relationship with Aetna in some way adverse to the</p> <p>15 other health insurers that it has a relationship with.</p> <p>16 So it's essentially an arm's length relationship at some</p> <p>17 level.</p> <p>18 If that's true, if all of things you have said</p> <p>19 are true and I take them at face value, what is the</p> <p>20 point of the merger?</p> <p>21 MR. MORIARTY: The merger is not a PBM centric</p> <p>22 merger, Commissioner. It is literally looking at how we</p> <p>23 can bring new models into healthcare to lower costs and</p> <p>24 get better patient benefits. So that can partially be</p> <p>25 accomplished through the PBM, but largely it has to be</p> <p>Page 72</p>
<p>1 MR. WINGLE: We're talking about a big</p> <p>2 investment as a joint company together to build a</p> <p>3 different model in the communities, and, you know, that</p> <p>4 means I think a long-term commitment that's more than a</p> <p>5 contract.</p> <p>6 COMMISSIONER JONES: But there's no legal</p> <p>7 prohibition against your contracting for exactly what</p> <p>8 you have just described, is there?</p> <p>9 MR. GREANEY: Right. But if we were to make a</p> <p>10 commitment to transform along the lines that I'm talking</p> <p>11 about and we're contract limited, it's not like we could</p> <p>12 build 11,000 retail clinics around the country on our</p> <p>13 own if that relationship were to end.</p> <p>14 We're looking for a permanent arrangement so</p> <p>15 that we can make those investments and confidently</p> <p>16 rebuild the health care system together.</p> <p>17 COMMISSIONER JONES: Does CVS want to add</p> <p>18 anything on that point?</p> <p>19 MR. MORIARTY: I guess on some levels,</p> <p>20 Commissioner, you're asking the core question as to why</p> <p>21 the current system has not been able to solve for the</p> <p>22 lack of coordination, the lack of integration in the</p> <p>23 system. And it's a great question and it's exactly what</p> <p>24 this transaction, this combination, is going to seek to</p> <p>25 solve for.</p> <p>Page 71</p>	<p>1 accomplished by developing new programs, new plans, that</p> <p>2 can lead to those outcomes.</p> <p>3 And the benefit, then, that will enure to CVS</p> <p>4 Health after Aetna and we work together to develop</p> <p>5 these, is that we can offer those to our existing client</p> <p>6 base, either through the pharmacy networks or through</p> <p>7 the PBM CareMark, to it's broader client set through the</p> <p>8 health plans that we serve today.</p> <p>9 So it's not a PBM centric merger, it is much</p> <p>10 more a health plan and health plan innovation centric</p> <p>11 merger.</p> <p>12 COMMISSIONER JONES: Aetna want to add</p> <p>13 anything?</p> <p>14 MR. WINGLE: We're also a diversified company</p> <p>15 and we offer a multitude of services and provide that</p> <p>16 same wall of protection.</p> <p>17 So, for example, we have a company within,</p> <p>18 within our walls that provides services analytics to</p> <p>19 state and regional plans to help them manage their</p> <p>20 administrative services-only arrangements with large or</p> <p>21 medium sized employers. So as a diversified company</p> <p>22 we're pretty well rehearsed and understand how you</p> <p>23 protect the integrity of each line of business.</p> <p>24 Again, I think the focus is moving away from</p> <p>25 thinking about the old divisions and silos to thinking</p> <p>Page 73</p>

<p>1 about knew capabilities we can bring together as we 2 bring our analytical tools and our networks of providers 3 together with that local presence to improve the health 4 model.</p> <p>5 COMMISSIONER JONES: Let me see if Ms. Rocco 6 has any questions.</p> <p>7 DEPUTY COMMISSIONER ROCCO: I just have a 8 follow-up question in the area having to do with the 9 \$750 million in potential annual savings.</p> <p>10 The testimony was that the most significant 11 portion of that savings would be due to increased 12 adherence, and I'm trying to figure out if you have a 13 company that has a lot of pharmacies, is a PBM, has a 14 lot of MinuteClinics, you're acquiring a health insurer, 15 not medical provider groups, but a health insurer.</p> <p>16 So how does the merger of those companies lead 17 to increased adherence specifically?</p> <p>18 MR. MORIARTY: It's a great question and I'll 19 answer it by way of an example.</p> <p>20 You know, we referenced just the overall 21 national impact here in California of diabetes and 22 prediabetics and what that means to the cost curve going 23 forward. And I think the best way to answer that 24 question is if you look, a patient with diabetes will 25 see their primary care physician four to maybe six times</p> <p>Page 74</p>	<p>1 MS. MIRANDA: Yeah, so think about going into 2 your pharmacy today. Today you go into your pharmacy 3 and if you, if your pharmacist as a question, they call 4 the doctor on the phone, right, and the doctor is seeing 5 patients and calls the pharmacist back at the end of the 6 day, and then you may have to go back to your pharmacy 7 tomorrow.</p> <p>8 Now imagine where, much like, think about the 9 electronic medical record, if the pharmacy system could 10 talk to the doctor system, if the pharmacy could have 11 almost a skinny EHR where it was part of that record and 12 it could send messages back to the doctor, "patient in 13 today" -- because if you go to a good pharmacy and you 14 talk to a good pharmacist, what you see when they stand 15 in line is they know about your dog, they know about 16 spouse, they know about your kids, right? They really 17 are embedded and have a great relationship with the 18 patient.</p> <p>19 And sometimes patients are, are shy about 20 talking about things with the doctor, they may feel a 21 little intimidated, that they might talk to with their 22 pharmacist.</p> <p>23 Now the pharmacist, instead of having to pick 24 up the phone and call and leave a message, maybe talk to 25 a nurse, maybe the doctor gets back to them the next</p> <p>Page 76</p>
<p>1 a year. That's what the data says.</p> <p>2 We know, though, that that same patient sees 3 their pharmacist and is in the pharmacy anywhere from 18 4 to 24 times a year.</p> <p>5 How do we then take better advantage of those 6 points of engagement at the pharmacy counter where we 7 can look at the care plan the physician has prescribed 8 for that patient and ensure, at least work more closely 9 on ensuring that they are adhering to that care plan.</p> <p>10 And as I mentioned, any increase in both the 11 testing for the blood sugar levels, blood glucose 12 levels, as well as adherence to medication therapy has 13 significant impacts not only the quality of health for 14 that patient but also, obviously, in the cost to the 15 system.</p> <p>16 So better using information, better using 17 data, and better leveraging the points of contact when 18 the patient wants to interact with the healthcare 19 system, that's where we think significant impact can be 20 made.</p> <p>21 DEPUTY COMMISSIONER ROCCO: Are you able to be 22 any more specific in terms of the acquisition of the 23 health insurer, how does that improve the patient's 24 experience when they are at the point of contact at 25 pharmacy? What changes?</p> <p>Page 75</p>	<p>1 day, we have a type of message that goes directly into 2 the EMR so the doctor, when they pull up the patient's 3 file, can see, oh, the patient didn't pick up their 4 medication for three months. Oh, the patient this 5 happened, that happened, and send a message back to the 6 pharmacist. All done electronically.</p> <p>7 That's a vision for a new way of communication 8 between a pharmacist and a doctor, where the doctor is 9 the hub, the doctor is in charge of the care, but the 10 pharmacist is able to supply information in a way that 11 doesn't happen today. It would be great if this 12 happened, but it doesn't.</p> <p>13 MR. WINGLE: I would like to embellish if I 14 could, because I think we have some examples of how are 15 analytics could really help that local approach.</p> <p>16 You know, Kristen mentioned in her testimony 17 about how US News and World Report, which has fantastic 18 datasets, worked with us through our foundation to rank 19 communities, to find the healthiest communities.</p> <p>20 Well, that same dataset we've used to look at 21 anomalies around the country and develop targeted 22 programs, culturally appropriate programs in communities 23 where there are issues, so we all understand the 24 disparities that exist around maternal health and 25 pregnancy and delivery and addressing those disparities,</p> <p>Page 77</p>

<p>1 that allowed us, that data allowed us to develop 2 targeted programs to ensure better maternal health in 3 minority communities where that presented as an issue in 4 our data. Same thing on an asthma intervention that 5 we've piloted. Same thing on a diabetes intervention. 6 So if we can take that data and develop with a 7 brick and mortar location and the resources around it, 8 more community based programs that address the dynamics, 9 the social deterrents within the community, I think it 10 will be a very powerful effect for the healthcare 11 system. 12 DEPUTY COMMISSIONER ROCCO: I have a question 13 on a separate issue having to do with PBMs. One of the 14 criticisms of the model that we use in this country 15 today is that there's not enough transparency. 16 There are, my understanding at least, is that 17 there are some PBM contracts that prohibit pharmacists 18 from disclosing to the patient that there are lower cost 19 drugs available or that if they didn't use their 20 insurance they could get the drug at a lower cost with 21 the CVS CareMark PBM. 22 Is that a practice that is used in any of your 23 contracts? 24 MR. MORIARTY: It is not, and there is 25 actually federal legislation prohibiting the use of so</p> <p>Page 78</p>	<p>1 you can see based off your formulary, where you are in 2 your deductible cycle, what your cost is for that drug, 3 and then as I indicated we also provide point of sale 4 rebate capabilities to some 10 million lives that the 5 plan sponsors have chosen to provide that to their 6 members. 7 So we have a number of programs to bring that 8 transparency to the consumer level. 9 COMMISSIONER JONES: Is it your intention to 10 provide those approaches to all of Aetna's 11 policyholders? 12 MR. MORIARTY: We offer these today, and 13 obviously the plan sponsor makes their determination in 14 terms of how they manage the benefit and the value they 15 deliver to the beneficiary for that plan. 16 But, yes, we have brought a number of 17 capabilities to other health plans as well in terms of 18 these capabilities. 19 COMMISSIONER JONES: Will Aetna as a result of 20 the merger automatically get access to that or will they 21 have to negotiate for it like every other plan has to 22 negotiate for it? 23 MR. MORIARTY: Like all the other plans today, 24 they have access to it and can make decisions as to how 25 they choose to put the benefits together.</p> <p>Page 80</p>
<p>1 called gag clauses that we fully support and have 2 indicated our support for that. 3 And then just on the transparency question, 4 because I do think it's important. The PBM model is 5 absolutely transparent to our clients. Our clients know 6 down to the drug level the cost associated with each 7 medication. They know fundamentally what our retained 8 rebates are, the administrative fee that they are paying 9 us. 10 So there's absolute transparency at the client 11 level, and we are now bringing that transparency and 12 drug cost transparency to consumers, both at our 13 pharmacy counters, as I indicated in my testimony, but 14 also now to the physician office through the use of the 15 electronic health record. So. 16 COMMISSIONER JONES: Just to be clear about 17 the client consumer distinction, when you say "clients," 18 you mean entities that the CareMark PBM are in a 19 contractual relationship with. So that's various payers 20 self insured, employers, health plans, health insurers, 21 those are the clients that have this transparency 22 currently. It's not the actual end user of the drug, 23 yet, that has that transparency? 24 MR. MORIARTY: Well, it is, actually, in the 25 new system that we launched about two months ago where</p> <p>Page 79</p>	<p>1 COMMISSIONER JONES: But what about after the 2 merger? 3 MR. MORIARTY: Absolutely, same -- nothing 4 changes today versus after the merger in terms of how we 5 will operate the CareMark business with health plans. 6 COMMISSIONER JONES: So that benefit, if you 7 will, of transparency will only be available if Aetna 8 decides to pay for it? 9 MR. MORIARTY: Actually there's no cost 10 associated with this. 11 I think Aetna may have some -- 12 MR. WINGLE: Right. We are already developing 13 the same transparency tools, so we are all moving in the 14 same direction. 15 COMMISSIONER JONES: Maybe I misunderstood, 16 though. I thought you were saying that CareMark offered 17 to some millions of consumers this transparency already 18 for those plans that have elected to have that. 19 I assumed that that meant they are paying 20 something for it. They're not? 21 MR. MORIARTY: It's part of the broader 22 offering we give them. 23 COMMISSIONER JONES: But there's no price 24 consequence associated with that as opposed to not 25 offering that?</p> <p>Page 81</p>

<p>1 MR. MORIARTY: No.</p> <p>2 COMMISSIONER JONES: Okay.</p> <p>3 Then we're going to hear some testimony I</p> <p>4 think in a little bit about a horizontal competitive</p> <p>5 aspect of this merger, if you will, and that is the</p> <p>6 implications of this merger on the availability of Part</p> <p>7 D prescription drug plans.</p> <p>8 Both of your companies in various ways,</p> <p>9 shapes, or forms offer Part D. There's some evidence</p> <p>10 that's been provided that we're going to hear about a</p> <p>11 little bit later on that indicates that under the metric</p> <p>12 that one uses to measure market consolidation, that this</p> <p>13 merger will result in some number of geographic areas</p> <p>14 being impacted in terms of decreased competition as it</p> <p>15 relates to the Part D prescription drug benefit.</p> <p>16 I want to give you a chance to respond to that</p> <p>17 now, and of course we'll give you a chance after you've</p> <p>18 had a chance to hear everybody else's testimony, to</p> <p>19 respond later.</p> <p>20 But it is an important issue to me, so I</p> <p>21 wanted to give you a chance to respond to it now.</p> <p>22 MR. MORIARTY: Okay. And again I'll start and</p> <p>23 others can add to it.</p> <p>24 But I think first and foremost the Medicare</p> <p>25 Part D and MAPD markets are highly competitive. The</p> <p>Page 82</p>	<p>1 LIS -- low income subsidy populations.</p> <p>2 For those that don't select, those are</p> <p>3 auto-enrolled by the government into plans on a yearly</p> <p>4 basis, and they are enrolled into plans that are below</p> <p>5 the benchmark. What the benchmark is varies each year</p> <p>6 depends on the bids, and you don't know whether you're</p> <p>7 above or below the benchmark when you bid.</p> <p>8 So what can see from year to year through the</p> <p>9 cycle, is shifts in share as though auto-enrollees are</p> <p>10 automatically put into plans by CMS that are below the</p> <p>11 benchmark. So you can see shifts in share.</p> <p>12 COMMISSIONER JONES: Let me be very specific.</p> <p>13 Professor Scheffler, who we're going to have a chance to</p> <p>14 hear from a little later on, has found in his study that</p> <p>15 30 Part D regions would experience an HHI increase of</p> <p>16 over 200 points as a result of CVS' acquisition of</p> <p>17 Aetna, and that's typically used as a threshold by</p> <p>18 federal DOJ and FTC as an indicator of a negative impact</p> <p>19 on competition, and that 10 of those 30 would have a</p> <p>20 post-merger HHI of greater than 2500.</p> <p>21 I'm sure he's going to explain in greater</p> <p>22 detail the nomenclature, but you're familiar with it,</p> <p>23 and so I'm wondering if you can speak specifically to</p> <p>24 that impact in particular regions across the United</p> <p>25 States associated with this merger.</p> <p>Page 84</p>
<p>1 statistics will be there for California. We can provide</p> <p>2 that level of analysis for you as well.</p> <p>3 I think what's really important as you look at</p> <p>4 the markets is that it is Part D as well as MAPD. When</p> <p>5 you look at those data and share numbers, I think the</p> <p>6 combined shares were in the 15 to 17 percent range,</p> <p>7 which clearly does not implicate any real competitive</p> <p>8 concerns.</p> <p>9 I think you see a highly competitive market,</p> <p>10 not only with the number of competitors and the large</p> <p>11 Fortune 5000 companies that compete, but also because of</p> <p>12 the annual bidding cycle that is part of the Part D</p> <p>13 program that is leading to lower and lower premiums each</p> <p>14 year and more efficient programs, and that has</p> <p>15 fundamentally been very efficient in actual lower costs</p> <p>16 than anticipated by the government accounting office.</p> <p>17 And I think what is really important as you</p> <p>18 look at this is, is that annual bidding cycle and what</p> <p>19 it means -- and actually I'll ask Ms. Ferguson to</p> <p>20 comment on it -- because those details are important as</p> <p>21 you look at this marked.</p> <p>22 MS. FERGUSON: Yeah, so the first thing I'd</p> <p>23 note is in California there are 25 different plans that</p> <p>24 are offered by ten companies currently, and it's</p> <p>25 important to remember that both Aetna and CVS have large</p> <p>Page 83</p>	<p>1 MS. FERGUSON: So I'm sorry, I have not seen</p> <p>2 his study so I don't know what regions he's talking</p> <p>3 about. We don't believe there is a certain in</p> <p>4 California. And to the extent the Department of Justice</p> <p>5 found a concern, divestiture would be an appropriate</p> <p>6 remedy for that.</p> <p>7 COMMISSIONER JONES: I'll give you a chance</p> <p>8 after you've had a chance to hear his testimony and look</p> <p>9 at his study to respond to it.</p> <p>10 Let me just ask this, then. In the interest</p> <p>11 of time I'm going to stop asking questions, and also to</p> <p>12 give our very able court reporter a break, and all of</p> <p>13 you a break, I think we're going to take a little</p> <p>14 ten-minute recess.</p> <p>15 I want to ask, if I have additional questions</p> <p>16 that I wasn't able to get to, can I present those to CVS</p> <p>17 in writing and within a reasonable time expect some sort</p> <p>18 of answer?</p> <p>19 MR. MORIARTY: Absolutely.</p> <p>20 COMMISSIONER JONES: And Aetna the same?</p> <p>21 MR. WINGLE: Of course.</p> <p>22 MS. MIRANDA: Of course.</p> <p>23 COMMISSIONER JONES: I appreciate that. And</p> <p>24 there were a couple of items during the course of the</p> <p>25 testimony you both very kindly consented to provide us</p> <p>Page 85</p>

<p>1 as well.</p> <p>2 So if there are additional questions that we</p> <p>3 have that we're not raising during this hearing, we'll</p> <p>4 provide you with something in writing and, you know,</p> <p>5 whatever reasonable amount of time you need to try to</p> <p>6 answer those would be appreciated.</p> <p>7 So we're going to take a ten-minute recess.</p> <p>8 We will reconvene at -- what's the pleasure of the court</p> <p>9 reporter?</p> <p>10 COURT REPORTER: It's 12:15, how about 12:25?</p> <p>11 COMMISSIONER JONES: 12:25 it is. Always pay</p> <p>12 attention to the court reporter. Very important.</p> <p>13 We'll reconvene at 12:25.</p> <p>14 (Off the record.)</p> <p>15 COMMISSIONER JONES: Okay. Why don't we</p> <p>16 resume our hearing, and we have got another panel of</p> <p>17 witnesses who are invited to come to the front. One of</p> <p>18 whom, Diana Moss, we're going to call in at that moment</p> <p>19 by phone, but I think everyone else is going to be here</p> <p>20 in person.</p> <p>21 First before we do that, those that wish to</p> <p>22 have a copy of the transcript, we encourage you to take</p> <p>23 the reporter's business card, which is up here on the</p> <p>24 counter in front of her, and then that will tell you how</p> <p>25 to get ahold of her in order to arrange to get a</p> <p>Page 86</p>	<p>1 do with all my public participation, including</p> <p>2 congressional testimony and filing Amicus briefs, I do</p> <p>3 so pro bono. I don't receive support from anyone either</p> <p>4 interested in this merger pro of con.</p> <p>5 So in my remarks today I would like to first</p> <p>6 offer a brief summary of the role of antitrust</p> <p>7 enforcement in healthcare and the current state of the</p> <p>8 law and economic analysis of vertical mergers in</p> <p>9 particular, and then move on to specifically address the</p> <p>10 issues presented by the CVS-Aetna merger.</p> <p>11 And let me just cut to the chase. My bottom</p> <p>12 line is this: The points I want to make are, first,</p> <p>13 that market concentration is a leading cause of high</p> <p>14 costs in healthcare and, second, that antitrust</p> <p>15 enforcement has really neglected the risks associated</p> <p>16 with vertical combinations and has concentrated on</p> <p>17 horizontal combinations, and both are presented in this</p> <p>18 merger.</p> <p>19 As a result of that neglect, a lot of the law</p> <p>20 is really out of date and not very much helpful for</p> <p>21 guidance.</p> <p>22 Now as you know, this merger is being</p> <p>23 carefully reviewed by the Department of Justice in</p> <p>24 Washington -- my alma mater actually, the antitrust</p> <p>25 division of the Department of Justice where I began my</p> <p>Page 88</p>
<p>1 transcript.</p> <p>2 We'll also post something on our website with</p> <p>3 regard to how to get a transcript as well -- oh, I stand</p> <p>4 corrected. We actually will post the transcript itself,</p> <p>5 too.</p> <p>6 It's my pleasure to ask the next set of</p> <p>7 witnesses to come forward, and I'd like to ask if they</p> <p>8 might introduce themselves, and then we'll jump right</p> <p>9 into this next panel.</p> <p>10 MR. GREANEY: I'm Tim Greaney, Professor of</p> <p>11 Law at UC Hastings College of Law and a fellow at the</p> <p>12 UCS Hastings Consortium on Healthcare Law.</p> <p>13 COMMISSIONER JONES: Excellent. And then the</p> <p>14 second witness is Professor Scheffler.</p> <p>15 MR. SCHEFFLER: I'm Richard Scheffler. I'm a</p> <p>16 professor of Health Economics at the Goldman School of</p> <p>17 Public Policy and the School of Public Health at</p> <p>18 Berkeley.</p> <p>19 COMMISSIONER JONES: Wonderful. And I think</p> <p>20 Professor Greaney will start.</p> <p>21 MR. GREANEY: Commissioner, thank you for the</p> <p>22 opportunity to participate in this proceeding, and thank</p> <p>23 you for conducting this proceeding. I think it's a very</p> <p>24 important issue that merits close attention.</p> <p>25 Let me just mention at the outset, that, as I</p> <p>Page 87</p>	<p>1 career -- and a lot of facts are being gathered, and</p> <p>2 those facts are essential to understanding the</p> <p>3 implications of these mergers.</p> <p>4 But that said, we can learn and we can sort of</p> <p>5 help steer the conversation by looking at what we know</p> <p>6 about market structures and incentives of the parties.</p> <p>7 Based on that, my view is, at least based on</p> <p>8 what we know right now, I think the CVS-Aetna merger has</p> <p>9 the potential, and is indeed likely, to lessen</p> <p>10 competition in the standalone prescription drug plan</p> <p>11 market.</p> <p>12 And secondly, that when you look at CVS-Aetna</p> <p>13 combining along with Express Scripts Cigna, which is</p> <p>14 also on the horizon, it will enhance incentives by</p> <p>15 foreclosing competition and raising rivals' costs.</p> <p>16 So by way of introduction, I just want to</p> <p>17 mention that I'm currently associated with the</p> <p>18 University of California. My remarks here represent</p> <p>19 only my own views, not those of the university, and I'm</p> <p>20 also a professor emeritus from St. Louis University</p> <p>21 where I spent 29 years.</p> <p>22 Most of my career, in fact, has been focused</p> <p>23 on the area of antitrust in healthcare. I've written</p> <p>24 numerous articles in that area, and I recently put out a</p> <p>25 two-part white paper with a colleague at Duke University</p> <p>Page 89</p>

<p>1 on the American Antitrust Institute web page that 2 covers, tries to cover comprehensively the issues 3 presented by healthcare competition and what should be 4 done going forward. And before that I was an assistant 5 chief in the antitrust division of the Department of 6 Justice where I supervised healthcare matters.</p> <p>7 So let me start with talking about the role of 8 antitrust in healthcare. The American antitrust 9 enforcement agencies, and by that I mean the FTC, the 10 Department of Justice, and the State Attorneys General, 11 have long devoted an extraordinary amount of their 12 resources to the healthcare sector.</p> <p>13 Examples include challenges to hospital 14 mergers, physician cartels, reverse payments by 15 pharmaceutical companies, insurance company mergers, and 16 anticompetitive practices. And in recent years it's 17 important to note that the agencies have won a series of 18 very important cases challenging horizontal mergers 19 among hospitals, horizontal mergers among physicians, 20 and horizontal mergers among insurance companies.</p> <p>21 These cases have gone a long way to clarify 22 the law and send a clear message that combining 23 competitors in concentrated local markets is going to 24 face close scrutiny.</p> <p>25 These cases actually reverse the series of</p> <p>Page 90</p>	<p>1 physician, health insurance, PBM markets.</p> <p>2 And in each sector, it's important to note, 3 that there are high barriers to entry, and proven, at 4 least in part, by the fact market shares have grown or 5 stabilized at high levels and entry has not righted the 6 boat in those cases.</p> <p>7 And finally, there are lots of studies showing 8 concentration in healthcare is associated with high 9 prices. And fundamentally, when you get down to it, the 10 healthcare markets are characterized by a variety of 11 unusual characteristics. Marketing elasticity, perfect 12 information, agency relationships, and that makes these 13 markets particularly vulnerable to market power and they 14 exacerbate the risks we see going forward with mergers.</p> <p>15 So let me turn to the issue of how the law 16 deals with vertical mergers.</p> <p>17 I submitted a draft article that is going to 18 be published soon in the American Journal of Law, 19 Medicine, and Ethics that summarizes my views. I begin 20 the article with a quote from George Orwell's novel 21 Animal Farm, in which one of the animals, Snowball, 22 describes his world view as "four legs good, two legs 23 bad." And I compare that to the Chicago School of 24 mergers, which is vertical good, horizontal sometimes 25 bad.</p> <p>Page 92</p>
<p>1 losses in hospital mergers, and I think they have 2 created what will be enduring legal precedents going 3 forward. Among other things they clarify that insurance 4 markets are highly localized, most of them are, there 5 are some national markets.</p> <p>6 These cases have rejected the arguments that 7 market power will be checked by the countervailing power 8 of large buyers, or vice versa large buyers will 9 counteract the market power of providers. What I refer 10 to in the Health Affairs article as the sumo wrestler 11 fallacy, that the two would get together and the 12 consumer would be better off.</p> <p>13 They've declined to accept arguments that the 14 uncertainties arising from the changing market structure 15 we see today justifies consolidation. And they have 16 just been quite skeptical, I think appropriately so, of 17 promised efficiencies.</p> <p>18 But that said, there's considerable evidence 19 that past consolidation, consolidation that in some 20 cases is the product of mergers that went unchallenged, 21 is responsible for the high cost of healthcare today.</p> <p>22 There's an extensive economic literature that 23 details, and I cite in my written testimony, that 24 details the amount of consolidation and the fact that it 25 has occurred in all of these sectors, hospital,</p> <p>Page 91</p>	<p>1 And that pretty much describes how government 2 enforcement has gone forward, and to a degree explains 3 why case law is sparse and really out of date in this 4 area.</p> <p>5 The important thing I would observe is 6 contemporary economic analyses have really questioned 7 the basis for that laissez-faire approach to vertical 8 combinations.</p> <p>9 The modern account shows that the 10 preconditions underlying the Chicago School's view, 11 quote, "rarely hold and can obscure how a merger may 12 enable conduct that limits rivalry at the horizontal 13 level."</p> <p>14 And I would commend for your summer beach 15 reading a really excellent article that just came out in 16 the Yale Law Journal by Steven Salop, one of the most 17 respected economists in this area, called Invigorating 18 Vertical Merger Analysis, where he really takes on the 19 assumptions that led to this laissez-faire approach and 20 suggests a more vigorous approach. Not that all or even 21 most vertical mergers are problematic, but clearly some 22 are.</p> <p>23 And the problem is that, as Commissioner said 24 earlier, they combine inputs with distribution and they 25 create incentives, they can create incentives, for the</p> <p>Page 93</p>



<p>1 merged firm to exclude its rivals downstream or 2 upstream, and they can do it two ways. They can either 3 cut them off or they can raise rivals' costs, that's 4 Professor Salop's term for charging discriminatory or 5 high or detrimental prices to a rival that gives the 6 integrated firm, the merged firm, the cushion to charge 7 higher prices. It gives them protection. And anyway, 8 there is extensive literature on that.</p> <p>9 So another faulty premise of the vertical 10 world view is the assumption that savings inevitably 11 flow from these kind of hierarchal vertical 12 arrangements. Economic evidence for this is lacking, 13 and you're going to hear from Professor Burns shortly, 14 economic integrations often fail to generate the 15 benefits that were promised.</p> <p>16 Not unlike horizontal mergers, vertical 17 mergers are subject to inherent problems when two 18 companies get together. Culture clashes, inadequate 19 information pre merger, challenges that are just 20 inherent in merging two entities.</p> <p>21 Another well known economist, Martin Gaynor, 22 put it concisely. He said "consolidation is not 23 coordination." And I think it's noteworthy to note that 24 antitrust law appropriately places a high bar on these 25 efficiencies justification.</p> <p>Page 94</p>	<p>1 familiar with was a case that was ultimately challenged 2 in Michigan involving insurers, an insurer with market 3 power, Blue Cross Blue Shield, insisting on most favored 4 nation's treatment in order to reduce rivalry from rival 5 insurers.</p> <p>6 So the antitrust law has actually been 7 relatively lenient, however, on conduct that's 8 exclusionary. It's more concerned with collusion 9 activity. And that explains why merger law is all the 10 more important. Because merger law is prophylactic. 11 It's designed to nip concentration in the bud before 12 firms get too big so they can exercise this. And 13 Professor Hovenkamp and others have argued where merger 14 is likely to lead to conduct that's both anticompetitive 15 but difficult or impossible for antitrust law to reach 16 once the merger has occurred, it's especially important 17 to pay attention to those.</p> <p>18 I'll be happy to talk a little more about the 19 recent AT&amp;T-Time Warner decision. Those of you who 20 haven't had the opportunity to read all 172 pages of it, 21 I have, and it certainly is an important case, but it 22 does not do what some of the press has tried to paint 23 it, as creating clear path for vertical mergers. In 24 fact it's very fact specific, and it doesn't even deal 25 with foreclosure.</p> <p>Page 96</p>
<p>1 Under the law in order to assuage competitive 2 concerns, an efficiency benefit must be achievable, one, 3 only through merger, two, it must offset potential 4 competitive harms, it must be pretty sizeable, and most 5 importantly, it must be passed on to consumers.</p> <p>6 For that reason there's never been a merger 7 decided by a federal court in which efficiency 8 justifications alone were sufficient to excuse a merger.</p> <p>9 And also important is mergers occur -- 10 benefits occurring outside the market in which 11 competition is harmed, are not considered. So the case 12 law has been pretty clear since the old Philadelphia 13 National Bank case, that you don't go looking for 14 benefits in side markets to justify an anticompetitive 15 merger.</p> <p>16 And a further reason for concern over vertical 17 integration that goes too far, is the experience that we 18 have seen in which market dominance by merger, that's 19 achieved by merger, can give rise to anticompetitive 20 conduct. So the history of antitrust law is littered 21 with examples of hospitals, physicians organizations and 22 insurers that have taken advantage of their dominant 23 position once they've gotten it through a merger, and 24 restrained competition going forward.</p> <p>25 An example I'm sure the Commissioner is</p> <p>Page 95</p>	<p>1 And the thing to remember about foreclosure 2 issues is that foreclosure has horizontal impact. 3 Foreclosure really says the merging firm has the 4 opportunity and the incentive to disadvantage rivals by 5 raising their costs or depriving them of customers. And 6 Time Warner doesn't do that, but just word of caution 7 because the press sometimes goes a little far on that.</p> <p>8 Let me now turn to the risks specific to 9 CVS-Aetna, and I'm just going to sort of introduce some 10 of the ideas that some of the other speakers are going 11 it talk about.</p> <p>12 We have seen in healthcare that provider 13 concentration, where a lot of the antitrust work has 14 been done, is not the only source of high costs. There 15 is really a legion of middlemen, many with market power 16 that can also extract costs. These risks were really 17 nicely summarized very recently in speech by the new FDA 18 Commissioner, Scott Gottlieb, and I'll just quote what 19 he said. He said "The top three PBMs control more than 20 two-thirds of the market, the top three wholesalers 80 21 percent, the top five pharmacies 50 percent. Market 22 concentration may prevent optimal competition, and so 23 the savings may not always be passed along to employers 24 or consumers."</p> <p>25 And he went on to say, "Too often we see</p> <p>Page 97</p>

<p>1 situations where consolidated firms, the PBMs, the 2 distributors and the drugstores, team up with payers. 3 They use their individual market power to effectively 4 split some of the monopoly rents with the large 5 manufacturers and other intermediaries rather than 6 passing along the savings garnered from competition to 7 patients and employers." And that sort of captures the 8 risks of vertical issues.</p> <p>9 And I think that observation, you're going to 10 hear, is echoed to some extent by Professor Sood's 11 empirical study, which finds out of every \$100 spending 12 by insured customers on pharmaceuticals, \$42 goes to 13 middlemen: PBMs, pharmacies, wholesalers, and insurance 14 companies.</p> <p>15 So antitrust analyses, as I mentioned, are 16 notoriously fact intense. There's a lot to be learned 17 here. And courts are asked to perform a predictive 18 exercise, predict future conduct and the effect on 19 competition. And to quote another famous economic 20 expert, Yogi Berra, "Predictions are very difficult, 21 especially about the future." And that's what we've 22 saddled the courts with doing here. But it necessarily 23 involves a close examination of facts, and the 24 Department of Justice is hard at work on this.</p> <p>25 But based upon what we know about structure</p> <p>Page 98</p>	<p>1 where they found they were separate and distinct 2 markets.</p> <p>3 They are different in the services provided, 4 consumer preferences, and regulation, and I'll leave it 5 to Professor Scheffler to talk about the increase in the 6 market shares that appear to be present in California 7 and at least 10 or 20 other states -- and he'll also 8 talk about the economic studies which show a correlation 9 between high concentration and higher prices.</p> <p>10 There are other aspects to this merger that 11 merit scrutiny. One is, another one you mentioned 12 earlier, which is the loss of potential competition. 13 Aetna acknowledged that it was contemplating entering 14 the PBM market at one time or another de novo, and that 15 would add to deconcentrating what is a concentrated PBM 16 market.</p> <p>17 That clearly has been a possible issue in 18 health law antitrust cases, and as you also mentioned, 19 CVS has a contract with the second largest insurer, 20 Anthem, to assist in its development of a PBM service, 21 and the inherent conflict in having CVS serve its new 22 insurance division -- Aetna -- and it's rival -- 23 Anthem -- presents serious concerns about coordination, 24 price fixing, market division, or resulting from the 25 information they have access to.</p> <p>Page 100</p>
<p>1 and the things you're going to hear today, there 2 certainly are ample grounds for concern. Let me first 3 talk about what your earlier dialogue touched on, the 4 horizontal effects of this merger.</p> <p>5 First of all, as to horizontal competition, as 6 most of you probably know the case law appropriately 7 places a presumption of competitive harm where market 8 shares and concentration is high and entry is not likely 9 to be timely or sufficient.</p> <p>10 There are good reasons for this. Not the 11 least of which is that mergers are permanent. Unlike 12 exclusive dealing contracts where there is competition 13 for the contract every year, two years, five years 14 there's competition, mergers don't have that character.</p> <p>15 And the horizontal concerns here, which we're 16 going to hear in a moment from Professor Scheffler, are 17 typical; two firms competing head-to-head in the 18 standalone prescription drug plan market, PDP market.</p> <p>19 And, by the way, contrary to what I think was 20 suggested earlier, I think there are good reasons to 21 treat the standalone PDP market separate and distinct 22 from the PDP options in Medicare Advantage plans. And 23 that certainly was a lesson we learned, and Commissioner 24 knows well, from the discussions of the Aetna merger, 25 attempted merger, that was dealt with with the courts</p> <p>Page 99</p>	<p>1 Now whether firewalls share that, solve that 2 problem is an open question. Some firms have been 3 satisfied with firewalls. But remember, firewalls will 4 only be as vigorous and as rigorous as the market makes 5 them be. And if we have a diluted competition with 6 these integrated entities, there's no reason to believe 7 that the firewalls will be airtight.</p> <p>8 The final aspect of horizontality here, if I 9 can use that word, is that if CVS-Aetna goes forward and 10 Express Scripts Cigna go forward, the consumer will only 11 be faced with three entities that actually serve 12 independent insurers, the smaller insurers that are out 13 there.</p> <p>14 And the important thing to note about that, is 15 these three integrated insurance PBM entities will have 16 aligned incentives. None will have incentives to offer 17 competitive terms to small insurers that are rivals of 18 their own insurance division. And there are widely 19 recognized barriers to entry. I think you addressed 20 that briefly with your dialogue earlier, Commissioner, 21 but there is some considerable writing, and I'll submit 22 an article by my colleague at Hastings, Robin Feldman, 23 that volume is what drives these rebates. They have to 24 offer significant volume to the pharmaceutical companies 25 to get a significant rebate. And that is an important</p> <p>Page 101</p>

<p>1 barrier to entry in this case.</p> <p>2 A new firm contemplating entry will also have</p> <p>3 to enter two markets. It will have to enter the PBM and</p> <p>4 insurance market, and at the same time some of the</p> <p>5 largest potential customers of that PBM service are</p> <p>6 already taken, as Aetna will be taken up as a customer</p> <p>7 of another PBM. So the emergence of a tight oligopoly</p> <p>8 of this magnitude with aligned incentives creates</p> <p>9 another risk.</p> <p>10 Finally, let me just turn briefly to the</p> <p>11 vertical aspects of this merger. The law is sparse</p> <p>12 here, as I mentioned, but a few things are clear about</p> <p>13 harm under Section 7 of the Clayton Act. Concerns are</p> <p>14 raised when a merger creates or strengthens incentives</p> <p>15 of firms to foreclose rivals or raise their costs for</p> <p>16 inputs necessary to compete.</p> <p>17 And I think you'll hear from Diana Moss, who</p> <p>18 put out a very comprehensive letter to the Assistant</p> <p>19 Attorney General of the Antitrust Division describing</p> <p>20 the risks that arise from structure and incentives, that</p> <p>21 it could change the incentives that CVS has as a</p> <p>22 standalone PBM right now to one in which it has a</p> <p>23 different and distinct interest when it acquires Aetna.</p> <p>24 And post merger, the argument goes, it will</p> <p>25 take into account the benefits its insurance subsidiary</p> <p>Page 102</p>	<p>1 There was a seven-year period when no hospital</p> <p>2 mergers were challenged by federal or state governments,</p> <p>3 and they did so because there was unfortunate precedent</p> <p>4 that came out of the courts. Precedent that we now</p> <p>5 recognize was wrongly decided. But those mergers, that</p> <p>6 wave of mergers produced excessive concentration that,</p> <p>7 in turn, resulted in higher prices for consumer</p> <p>8 services. And the FTC did some marvelous studies about</p> <p>9 the cases that it lost, showing that they were right,</p> <p>10 that prices did go up. In fact one is right here in our</p> <p>11 own backyard, Sutter, where the post-merger analysis</p> <p>12 showed the price went up even though the court allowed</p> <p>13 the merger to go forward.</p> <p>14 So I think, likewise, the benign neglect of</p> <p>15 vertical mergers between hospitals and physicians have</p> <p>16 resulted in higher prices. The government has never</p> <p>17 challenged a vertical merger between hospitals and</p> <p>18 physicians, and now economic studies are showing that</p> <p>19 those combinations, where they are sizeable, produce</p> <p>20 higher costs in the physician market. Again, this is</p> <p>21 the product of oversight.</p> <p>22 So with most healthcare sectors highly</p> <p>23 concentrated and competition anemic in many of them, I</p> <p>24 think vertical mergers have to be closely monitored.</p> <p>25 COMMISSIONER JONES: Thank you very much,</p> <p>Page 104</p>
<p>1 may achieve by providing less favorable terms to its</p> <p>2 insurance rivals.</p> <p>3 No how do we know which will prevail, the</p> <p>4 incentives to keep your PBM healthy or to benefit your</p> <p>5 insurance subsidiary? And I think you'll hear from</p> <p>6 Professor Sood some very interesting analysis of the</p> <p>7 relative margins of insurance versus PBMs that suggests</p> <p>8 that there's a very real possibility that this effect</p> <p>9 will be realized and it will harm competition.</p> <p>10 There's also a discussion present of whether</p> <p>11 CVS-Aetna will have incentive to disadvantage retail</p> <p>12 pharmacies, the independent pharmacies. The risk here</p> <p>13 is what economists like to call "customer foreclosure."</p> <p>14 CVS will have strong incentives, in some markets at</p> <p>15 least, to deprive rival pharmacies of competitive access</p> <p>16 to Aetna's insured -- "steering" as you put it</p> <p>17 earlier -- where it has a sizeable presence, raising</p> <p>18 rival costs. Tactics of this kind can be destructive of</p> <p>19 price and service competition.</p> <p>20 So let me close with sort of a cautionary tale</p> <p>21 about overlooking market concentration. The nation has</p> <p>22 really learned the hard way about overlooking</p> <p>23 consolidation in healthcare. It's learned the hard way</p> <p>24 that that oversight, in the bad sense of the word</p> <p>25 oversight, is costly.</p> <p>Page 103</p>	<p>1 Professor Greaney.</p> <p>2 Now we'll have a chance to here from Professor</p> <p>3 Scheffler.</p> <p>4 MR. SCHEFFLER: Thank you, Commissioner Jones.</p> <p>5 So a little bit more about a background just</p> <p>6 briefly. I have already told you I'm a distinguished</p> <p>7 professor of health, economics, and public policy at the</p> <p>8 School of Public Health in the Goldman School of Public</p> <p>9 Policy at the University of California Berkeley.</p> <p>10 I also hold the chair in the Healthcare</p> <p>11 Markets and Consumer Welfare endowed by the Office of</p> <p>12 the Attorney General for the State of California, and</p> <p>13 the founding director of Nicholas C. Petra Center on</p> <p>14 Healthcare Markets and Consumer Welfare.</p> <p>15 My longer CV is attached.</p> <p>16 I have testified for the Commissioner before.</p> <p>17 I testified at the California Department of Insurance</p> <p>18 January 22, 2016 hearing of the Centene Corporation's</p> <p>19 proposed acquisition of Health Net, and the California</p> <p>20 Department of Insurance March 29th, 2016 hearing on</p> <p>21 Anthem's proposed acquisition of Cigna Corporation.</p> <p>22 I've also testified at the Federal Trade</p> <p>23 Commission and the Department of Justice meeting</p> <p>24 examining healthcare competition in Washington D.C.,</p> <p>25 February 25th, 2015.</p> <p>Page 105</p>

<p>1 I want to thank the American Medical 2 Association for supporting my work and research in this 3 area and also for the help in preparing and support for 4 preparing this testimony. 5 Let me make it clear that my testimony 6 reflects my views and opinions, not necessarily the 7 views of the American Medical Association. 8 Little background. In 2018, 43 million of 9 60 million people with Medicare had prescription drug 10 coverage on the Medicare Drug D plan. 11 Of the 43 million, 25 million are covered 12 under a standalone prescription drug plan -- which I'll 13 call PDP -- while the remaining 18 million, or 14 42 percent, are enrolled in Medicare's Advantage 15 prescription drug plans. 16 In California, 2.3 million people are enrolled 17 in a PDP plan, while 2.5 million are enrolled in a 18 Medicare Advantage plan. 19 My professional opinion is similar to Tim 20 Greaney that you have heard, that the PDP and the 21 Medicare Advantage markets are separate markets due to 22 the lack of plan switching across the markets after the 23 initial enrollment the choice. 24 There is also an excellent study that I have 25 recently reviewed by the Kaiser Family Foundation</p> <p>Page 106</p>	<p>1 rose 11 percent from \$37 to \$41 per month. 2 In Figure 1, I also show how average monthly 3 premiums for PDPs have changed in California since 2006. 4 The California line you see is the red line. 5 In 2006 the average monthly premium in 6 California was \$20, which was 23 percent below the 26 7 national average. By 2011, however, the average monthly 8 premiums in California had caught up to the national 9 average of \$38. 10 Similar to national premiums, California 11 premiums were stable from 2011 to 2015. However, since 12 2015 California premiums have increased by 18 percent, 13 from \$38 to \$45, and today California premiums are ten 14 percent above the national average. Overall, California 15 premiums have increased 125 percent since 2006. 16 My testimony here focuses on the horizontal 17 overlap between CVS and Aetna in California's PDP 18 market. I specifically measure market concentration 19 before and after the proposed merger and the potential 20 impact on PDP market in California. 21 How Part D Premiums Are Determined. Part D 22 plan's sponsors compete on premiums to attract 23 enrollees, but do not set premiums directly. Plan 24 sponsors submit bids to the Center for Medicare and 25 Medicaid Services -- CMS -- and represents the revenue</p> <p>Page 108</p>
<p>1 entitled "To Switch or Not to Switch: Are Medicare 2 Beneficiaries Switching Drug Plans to Save Money," and 3 the answer is they are not switching between these two 4 markets. 5 The total drug costs of the Medicare Plan D 6 claims have increased rapidly since 2013. Nationwide, 7 total Medicare Part D drug costs increased from 103.7 8 billion to 146.1 billion, a 41 percent increase between 9 2013 and 2016. 10 In California the increase was slightly higher 11 in percentage term. The total Medicare Plan D drug 12 increasing from 10.5 billion in 2013 to 15.1 billion in 13 2016, a 44 percent increase. 14 Additionally, monthly Part D consumer premiums 15 have increased by 58 percent since the start of the 16 Medicare Part D program in 2006. During the same time 17 period, the consumer price index, the CPI, increased 18 only 24 percent. 19 In 2006 average monthly consumer premiums were 20 \$26 across the United States -- see Figure 1 where it's 21 up on the board there. 22 Average monthly consumer premiums leveled out 23 from 2010 to 2015, hovering around \$38 -- as you can see 24 from Figure 1. 25 Since 2015 average monthly consumer premiums</p> <p>Page 107</p>	<p>1 requirements including administrative costs and profits 2 for delivering basic benefits to an enrollee of average 3 health. 4 CVS then calculates a nationwide enrollment 5 weighted average among all bid submissions. The monthly 6 premium on an enrollee for a plan is a subsidized base 7 premium -- \$35 in 2018 -- plus or minus any difference 8 between his or her plan bid and the national average. 9 If an enrollee picks a plan that contain supplemental 10 coverage, the enrollee pays the full price of the 11 additional coverage. 12 Part D bidding process also determines the 13 maximum premium that Medicare will pay on behalf of the 14 low-end subsidized enrollee. The amount is calculated 15 separately for each of the Part D geographic regions as 16 an average premium among the plans with basic benefits 17 weighted by each plan's LIS enrollment in the previous 18 year. 19 Twenty-five of the 34 national Part D 20 geographic regions, excluding territories -- including 21 California -- are a single state, as you can see from 22 the map. The remaining nine regions are comprised of 23 multiple states. The formula used for LIS programs 24 ensures that at least one standalone PDP in each region 25 is available to LIS enrollees at no premium.</p> <p>Page 109</p>

<p>1 The importance of the 35 Part D regions in the</p> <p>2 determination of the maximum premium amount Medicare</p> <p>3 will pay on behalf of the LIS enrollees, plus the fact</p> <p>4 that the plan's sponsors must offer a plan in at least</p> <p>5 one entire region -- they cannot pick and choose among</p> <p>6 the geographics within a region that offers plans --</p> <p>7 makes Part D regions the geographic level which</p> <p>8 antitrust authorities are likely to examine in the CVS</p> <p>9 and Aetna overlap in the PD market. Hence Part D</p> <p>10 regional level PDP market concentration is analyzed in</p> <p>11 what follows.</p> <p>12 Measuring Market Concentration. I use the</p> <p>13 Herfindahl Hirschman Index -- which is called HHI -- to</p> <p>14 measure PDP in market concentration. The HHI has been</p> <p>15 used frequently as a measure of market concentration in</p> <p>16 merger cases brought by the antitrust division of the</p> <p>17 U.S. Department of Justice and the Federal Trade</p> <p>18 Commission, and is used in horizontal merger</p> <p>19 guidelines -- hereafter called "guidelines" -- authored</p> <p>20 by these agencies.</p> <p>21 HHI is calculated by taking the market share</p> <p>22 of each firm, squaring it, and summing the results. The</p> <p>23 HHI values range from zero to 10,000.</p> <p>24 Guidelines consider markets where the HHI is</p> <p>25 between 1500 and 2500 points to be moderately</p> <p>Page 110</p>	<p>1 Market Concentration Trends and Post Merger</p> <p>2 HHIs. Table 2 shows in 2018 the USPDP enrollment and</p> <p>3 market shares by parent organization. Currently, three</p> <p>4 parent organizations, CVS, United Health and Humana,</p> <p>5 account for 65 percent of the US PDP enrollment. A</p> <p>6 combined CVS-Aetna would lead to three parent</p> <p>7 organizations accounting for 73 percent of the USPDP</p> <p>8 enrollment.</p> <p>9 Table 3 shows in 2018, California's PDP</p> <p>10 enrollment and market share by parent organization.</p> <p>11 Currently there are three parent organizations, United</p> <p>12 Health, CVS, and Humana, account for 74 percent of</p> <p>13 California's PDP enrollment. A combined CVS-Aetna would</p> <p>14 lead to three parent organizations, accounting for</p> <p>15 83 percent of California's PDP enrollment.</p> <p>16 Table 3 lists all the other competitor's</p> <p>17 parent organizations in California.</p> <p>18 Figure 3 shows the PDP market HHI weighted by</p> <p>19 PDP enrollment from 2009 to 2018 across the United</p> <p>20 States. In 2009 the U.S. HHI was 1109, just above the</p> <p>21 guideline's 1500 threshold for moderately concentrated</p> <p>22 markets. By 2018 the U.S. HHI had increased to 1861, an</p> <p>23 increase of 342 HHIs or a 23 percent increase.</p> <p>24 The triangle in Figure 3 represents the U.S.</p> <p>25 HHI in 2018 if CVS and Aetna are treated as a single</p> <p>Page 112</p>
<p>1 concentrated, and markets with HHIs in excess of 2500 to</p> <p>2 be highly concentrated. Market shares in each of the 24</p> <p>3 Medicare Part D regions were calculated based on plan</p> <p>4 sponsored PDP enrollment.</p> <p>5 To address the impact of CVS-Aetna merger on</p> <p>6 PDP market concentration, 2018 marked concentration was</p> <p>7 calculated in two ways. One, assuming CVS and Aetna</p> <p>8 were separate firms -- that's the pre merger HHI. Two,</p> <p>9 assuming CVS and Aetna were a single firm -- post merger</p> <p>10 HHIs.</p> <p>11 Market concentration measured from 2009 to</p> <p>12 2017 were also calculated to show the trend in the PBP</p> <p>13 market.</p> <p>14 In the context of the guidelines assigned</p> <p>15 highest certain and scrutiny to mergers which would</p> <p>16 increase HHIs by over 200 points and lead the market</p> <p>17 with an HHI of 2500 -- you can see that from Table 1</p> <p>18 that I have indicated with yellow marking.</p> <p>19 Other HHI changes and levels trigger different</p> <p>20 degrees of concern and scrutiny -- see Table 1 for</p> <p>21 details.</p> <p>22 Markets that would experience HHI increases of</p> <p>23 over 200 points and result in HHIs at or above 1500 --</p> <p>24 again see the yellow cells -- will be discussed in the</p> <p>25 analysis that follows.</p> <p>Page 111</p>	<p>1 firm in HHI calculations. If CVS and Aetna were a</p> <p>2 single firm, the U.S. HHI would increase 410 points</p> <p>3 higher by 2018 than it is currently.</p> <p>4 Mergers that lead to an HHI change of over 200</p> <p>5 points and resulting in an HHI between 1500 and 2500,</p> <p>6 quote, "Potentially raise significant competitive</p> <p>7 concerns and often warrant scrutiny" according to the</p> <p>8 guidelines.</p> <p>9 Figure 3 also shows California's HHI from 2009</p> <p>10 to 2018. From 2009 to 2013, California's HHI lied below</p> <p>11 the national average indicated by the red line.</p> <p>12 Between 2013 and 2015, California was almost</p> <p>13 completely on line with the national average -- the</p> <p>14 national average being the dotted line.</p> <p>15 Since 2015, California's HHI has moved above</p> <p>16 the national average. This mirrors the pattern I</p> <p>17 discussed earlier between the U.S. and California's PD</p> <p>18 premium market in Figure 1. That is, the observed HHI</p> <p>19 increase is similar to the increase in premiums over the</p> <p>20 same time period. Today California's HHI is 2,007, 136</p> <p>21 points above the national average.</p> <p>22 The diamond in Figure 3 represents</p> <p>23 California's HHI in 2018 if CVS and Aetna are treated as</p> <p>24 a single firm in HHI calculations. If CVS and Aetna</p> <p>25 were a single firm, California's PDP market would be 434</p> <p>Page 113</p>

<p>1 points higher in 2018 than it is currently, a 22 percent 2 increase.</p> <p>3 Mergers that lead to an HHI change of over 200 4 points resulting in an HHI between 1500 and 2500 are, 5 quote, "potentially raise significant competitive 6 concerns and often not warrant scrutiny" according to 7 the guidelines.</p> <p>8 Table 4 shows how pre and post merger HHIs for 9 each of the 34 Part D markets -- I hope you can see 10 that, it's a little small -- overall, 30 of the Part D 11 regions would experience an HHI increase of over 200 12 points as a result of the CVS acquisition of Aetna. Of 13 these 30 regions, 10 would have a post merger HHI of 14 greater than 2500.</p> <p>15 Mergers that increase HHIs by over 200 points 16 and result in a post merger HHI of over 2500 are, quote, 17 "presumed to be likely to enhance market power" 18 according to the guidelines.</p> <p>19 The post-merger HHIs of the other 20 regions 20 would experience increases of 200 points, would all be 21 in the 1500 to 2500 range, and thus the merger would 22 trigger moderate concerns in these regions, according to 23 Table 1.</p> <p>24 A merger in California with a post-merger HHI 25 of 2,441 -- an increase of 434 points -- is one of the</p> <p>Page 114</p>	<p>1 including California.</p> <p>2 Thank you, Commissioner.</p> <p>3 COMMISSIONER JONES: Thank you, Professor 4 Scheffler. It's a privilege to see you again and to 5 have you testify again before the California Department 6 of Insurance.</p> <p>7 Our next witness is Professor Neeraj Sood. 8 Please, welcome. Why don't you take a seat to the right 9 of Professor Greaney. And after we hear from you -- do 10 you want to call -- what we're going to do is we're 11 going to call Diana Moss so she can hear Professor 12 Sood's testimony as well.</p> <p>13 Just a minute. We're trying bring in 14 Professor Moss.</p> <p>15 Hi, Professor Moss. Can you hear me? 16 MS. MOSS: I can, yes.</p> <p>17 COMMISSIONER JONES: This is Commissioner Dave 18 Jones, and you are now live before an audience of 50 19 people here and live streaming on various social media 20 as well. I appreciate you joining us.</p> <p>21 I think we're now at the point in our hearing 22 where we're going to hear from Professor Sood, and then 23 after Professor Sood, then we'll go to you, with your 24 permission.</p> <p>25 MS. MOSS: Very good. That works great.</p> <p>Page 116</p>
<p>1 20 regions that fall just below being, quote, "presumed 2 to be likely to enhance market power" according to the 3 guidelines. And I guess Table 4 lists all of the 4 markets.</p> <p>5 Impact of Proposed CVS-Aetna merger on 6 Medicare Part D Premiums.</p> <p>7 I have reviewed a large number of studies that 8 are cited in my testimony, and provide evidence that 9 increases in market power raise Medicare Part D 10 premiums.</p> <p>11 Based on these studies and my own analysis, 12 the proposed merger of CVS and Aetna will have important 13 and significant impacts on the concentration of the 14 Medicare Part D standalone prescription drug plan, PDP, 15 market.</p> <p>16 In 10 of the 34 PDP regional markets, the 17 merger should be, quote, "presumed to be likely to 18 enhance market power" according to the guidelines. An 19 additional 20 of the 34 PDP regional markets, the merger 20 would potentially, quote, "potentially raise significant 21 competitive concerns and often warrant scrutiny" 22 according to the guidelines.</p> <p>23 This later competitive concern was found in 24 California, and it is my opinion that the merger would 25 raise PDP premiums in markets across the country</p> <p>Page 115</p>	<p>1 COMMISSIONER JONES: And if you want to mute 2 your phone while we're hearing from Professor Sood, if 3 they're any intervening variables in your life like 4 children and cats and dogs, we might not hear those as 5 well -- if you're at home.</p> <p>6 All right. Professor Sood.</p> <p>7 MR. SOOD: So thank you very much for giving 8 me the opportunity to present today.</p> <p>9 I want to start with a couple of disclosures. 10 The first is that the support for some of the research 11 cited in the presentation today, as well as my 12 appearance at this hearing, was supported by the 13 American Medical Association.</p> <p>14 What I'm going to talk about today is my views 15 and opinions and not necessarily those of the AMA or of 16 my employer, the University of Southern California.</p> <p>17 I will start by talking a little bit about 18 myself. So I'm Professor of Health Policy and the Vice 19 Dean for Research at the Sol Price School for Public 20 Policy, and a professor at the Schaeffer Center at the 21 University of Southern California.</p> <p>22 My past research has focused on health 23 insurance markets, pharmaceutical markets, and global 24 health. I have published more than 100 papers, reports 25 in top peer reviewed journals in economics, medicine,</p> <p>Page 117</p>

<p>1 and health services research.</p> <p>2 I'm also the associate editor of two leading</p> <p>3 journals in my field, the Journal of Health Economics</p> <p>4 and Health Services Research.</p> <p>5 This next accomplishment I'm particularly</p> <p>6 proud of, that both the Council of Economic Advisors of</p> <p>7 President Obama, as well as President Trump, have cited</p> <p>8 my work on the pharmaceutical supply chain and my other</p> <p>9 work on healthcare costs.</p> <p>10 I have also been -- but I have not been</p> <p>11 treated by President Trump so far.</p> <p>12 I have also --</p> <p>13 COMMISSIONER JONES: Hope springs eternal for</p> <p>14 you that you forever avoid that distinction.</p> <p>15 MR. SOOD: I have been a scientific advisor</p> <p>16 for several organizations in the healthcare industry.</p> <p>17 So what I'm going to do today is first give</p> <p>18 you, or, you know, give the audience, an overview of how</p> <p>19 drugs reach from manufacturers s to consumers. This is</p> <p>20 a fairly complex supply chain, and I'm a professor, I</p> <p>21 love to lecture, so I'm going to start by just kind of</p> <p>22 setting the stage, and then I'll move to kind of the</p> <p>23 question today, which is how will the proposed merger</p> <p>24 between CVS and Aetna affect competition in the</p> <p>25 insurance market, PBM market, and pharmacy market, and</p> <p>Page 118</p>	<p>1 wholesaler.</p> <p>2 The manufacturer sometimes offers consumers</p> <p>3 copay assistance, which is they will help defray some of</p> <p>4 the out-of-pocket cost for the consumer. I'll get a</p> <p>5 coupon which I can take to a pharmacy and cover some of</p> <p>6 my cost.</p> <p>7 The manufacturer also makes payment to a PBM,</p> <p>8 which is commonly referred to as a rebate. The PBM also</p> <p>9 receives payment from a health plan, and it collects</p> <p>10 some of this money and passes. So every time I as an</p> <p>11 insured consumer buy a drug from a pharmacy, the PBM</p> <p>12 reimburses the pharmacy for my drugs. The PBM also</p> <p>13 shares some, or a lot, of these rebates back with the</p> <p>14 health plan with which it has contracted.</p> <p>15 So if you look at what services are offered by</p> <p>16 different entities then, so the manufacturer is doing</p> <p>17 the R&amp;D for the drug; the wholesaler is kind of managing</p> <p>18 the drug inventory, has large warehouses to store the</p> <p>19 drugs; the pharmacy in some sense is the retail store</p> <p>20 front, so they have costs related to operating all these</p> <p>21 stores.</p> <p>22 The PBM is, in some sense, truly a middleman</p> <p>23 in that they really don't touch the drugs, but they are</p> <p>24 kind of the middleman that helps the health plan</p> <p>25 negotiate with the pharmaceutical firm, and it also</p> <p>Page 120</p>
<p>1 then finally I'll offer some concluding thoughts.</p> <p>2 So if you look at how manufacturers are the</p> <p>3 ones who come up with a drug or do R&amp;D for the drug and</p> <p>4 produce the drug, so from manufacturers the drugs are</p> <p>5 sold to wholesalers, wholesalers in turn sell drugs to</p> <p>6 pharmacies, and then, you know, we as consumers go and</p> <p>7 buy our drugs from pharmacies. So the flow of drugs is</p> <p>8 from the manufacturer to the wholesaler to the pharmacy</p> <p>9 to the beneficiary.</p> <p>10 And this seems like a fairly simple or easy</p> <p>11 flow. But when you start looking at how money changes</p> <p>12 hands, there are two new entities that many come in to</p> <p>13 play. One is the PBM, and the other is a health plan.</p> <p>14 So I as a consumer pay some copay or cost sharing to the</p> <p>15 pharmacy when I purchase a drug, but I also pay a</p> <p>16 premium to my health insurance plan who helps cover some</p> <p>17 of my drug costs. Some of my premiums are paid by me</p> <p>18 out-of-pocket and some of them are paid by my employer,</p> <p>19 in this case USC.</p> <p>20 The pharmacy, in turn, buys drugs or pays</p> <p>21 money to a wholesaler to buy drugs from them. So there</p> <p>22 is a price or drug acquisition cost for the pharmacy</p> <p>23 that is received by the wholesaler. The wholesaler when</p> <p>24 they are done, buys the drug from the manufacturer. So</p> <p>25 there is a wholesale acquisition cost for the</p> <p>Page 119</p>	<p>1 helps the health plan negotiate with pharmacies. So</p> <p>2 they help negotiate pharmacy reimbursement as well as</p> <p>3 the level of rebates or discounts they are going to get</p> <p>4 from the manufacturer.</p> <p>5 And the health plan plays an important role in</p> <p>6 terms of providing financial risk protection to</p> <p>7 consumers. So we as consumers, once we have insurance,</p> <p>8 are shielded from very high medical care costs or</p> <p>9 prescription drug costs.</p> <p>10 So what we did was we kind of took this</p> <p>11 conceptual framework and then looked at publicly</p> <p>12 reported statements to the Securities and Exchange</p> <p>13 Commission of top pharmaceutical firms, wholesalers,</p> <p>14 retailers, pharmacy benefit managers and health plans,</p> <p>15 and then we try to estimate this question which is if I</p> <p>16 as a consumer spent \$100 on a drug, how much of that</p> <p>17 money eventually reaches the manufacturer and how much</p> <p>18 of that accrues to different bodies in the</p> <p>19 pharmaceutical supply chain.</p> <p>20 So what we find from this data is that if I</p> <p>21 have \$100 in spending on drugs, about \$42 goes to</p> <p>22 middleman, and \$58 reaches the pharmaceutical firm. And</p> <p>23 the way it is divided among the middlemen is insurers</p> <p>24 receive about 19 out of those \$100, PBMs receive about</p> <p>25 five, wholesalers receive about two, and the remaining</p> <p>Page 121</p>

<p>1 amount goes to pharmacies.</p> <p>2 So you can also look at what is the true or</p> <p>3 net profits of each of the players in the pharmaceutical</p> <p>4 supply chain, and what we find is of every \$100 in</p> <p>5 spending, \$23 goes toward profits, and of these profits</p> <p>6 about \$3 accrue to insurers, \$2 to PBMs, about \$3 to</p> <p>7 pharmacies, and about .30 to wholesalers and \$15 to</p> <p>8 manufacturers.</p> <p>9 So some of these net profit numbers are</p> <p>10 important because they highlight the incentives in</p> <p>11 different parts of the market, and I'm going to come</p> <p>12 back to that later in the presentation.</p> <p>13 So one question we might ask is, you know,</p> <p>14 given that these players are making \$23 in profit out of</p> <p>15 every \$100 in consumer spending or middlemen are keeping</p> <p>16 \$42 out of \$100 in consumer spending, are there some</p> <p>17 entities in the supply chain that are making too much</p> <p>18 money or are they making excess profit?</p> <p>19 And what our study did is, we could not answer</p> <p>20 that question directly. Our study in some sense is a</p> <p>21 descriptive study where we're just saying they are</p> <p>22 making \$42 or they're making \$23. So one way economists</p> <p>23 try to answer this question, whether a certain industry</p> <p>24 segment is making more money or not, is by looking at</p> <p>25 market power or looking at how concentrated these</p> <p>Page 122</p>	<p>1 consumer is, the price could vary. So if you go in and</p> <p>2 you say "I want drug X," you might get a certain price.</p> <p>3 But if you say, "Oh, by the way, I have an online</p> <p>4 coupon" you get another price, and if you ask for</p> <p>5 another discount you might get some other price. So</p> <p>6 there is a lot of price discrimination in the pharmacy</p> <p>7 market, especially for the uninsured consumers.</p> <p>8 Some of my colleagues at the Schaeffer Center</p> <p>9 did a study where they showed that a lot of times</p> <p>10 consumers what they pay out of pocket, insured consumers</p> <p>11 what they pay out of pocket as co-insurance or copay,</p> <p>12 could exceed the drug acquisition cost for the insurer.</p> <p>13 So from a consumer's perspective, not only are they</p> <p>14 paying premiums to the insurer, but even their</p> <p>15 out-of-pocket cost is higher than the drug acquisition</p> <p>16 cost for the insurer.</p> <p>17 So in substance if they didn't have insurance,</p> <p>18 they could actually have gotten the drugs at a cheaper</p> <p>19 price and at the same time saved premiums.</p> <p>20 The third thing related to this practice, is</p> <p>21 that because this happens, PBMs sometimes have gag</p> <p>22 clauses, which basically forbid a pharmacy from telling</p> <p>23 a consumer that if they didn't use their insurance card,</p> <p>24 they would have actually got the drug for cheaper.</p> <p>25 There is a lot of report from policymakers as</p> <p>Page 124</p>
<p>1 industries are.</p> <p>2 So if you look at market power, what you will</p> <p>3 see is a lot of the pharmaceutical supply chain is</p> <p>4 characterized by tremendous market power or being highly</p> <p>5 concentrated industry. So the top three PBMs account</p> <p>6 for 70 percent of the market. The top three pharmacies</p> <p>7 account for 50 percent. The top three wholesalers</p> <p>8 account for 90 percent of the market and so on.</p> <p>9 And what happens is -- there's a lot of both</p> <p>10 reports in the scientific literature as well as media</p> <p>11 reports -- showing how this market power manifests in</p> <p>12 practices that might potentially be hurting consumers.</p> <p>13 So what we find, what the reports say is -- so</p> <p>14 I did a study where we showed that within the same</p> <p>15 geographic markets, so within a small, like within the</p> <p>16 same zip code around USC, if an uninsured consumer goes</p> <p>17 to buy a drug at different pharmacies, there is a</p> <p>18 tremendous amount of price variations across pharmacies</p> <p>19 within the same zip code.</p> <p>20 So this is, again, this kind of price</p> <p>21 discrimination where some pharmacies have brand power</p> <p>22 and are selling drugs at a much higher price compared to</p> <p>23 other pharmacies, is a classic symptom of market power.</p> <p>24 Sometimes what we found was even within the</p> <p>25 same pharmacy, depending upon how sophisticated a</p> <p>Page 123</p>	<p>1 well as, you know, in the media saying that PBMs often</p> <p>2 do not disclose the amount of rebates they get, so</p> <p>3 therefore it's unclear how much of the rebates are being</p> <p>4 kept by PBMs and how much of them are eventually being</p> <p>5 passed on to health plans and then from health plans</p> <p>6 eventually to consumers.</p> <p>7 There is also this narrative that PBMs,</p> <p>8 because of their market power, demand higher and higher</p> <p>9 rebates. Pharmaceutical firms in response to that</p> <p>10 increase their list prices so as not to affect their</p> <p>11 revenues. But what happens with higher list prices is</p> <p>12 that if you are a consumer in a high deductible health</p> <p>13 plan, you are responsible for paying the list price of</p> <p>14 the drug, not the actual drug acquisition cost for the</p> <p>15 insurer.</p> <p>16 So now basically, again, the system is</p> <p>17 creating incentives where, especially consumers in high</p> <p>18 deductible plans, are left footing the bill for the high</p> <p>19 prices.</p> <p>20 So now I'm going to talk about the merger and</p> <p>21 what potential affect it might have on the health</p> <p>22 insurance market.</p> <p>23 So the first thing about health insurance</p> <p>24 markets is that they are highly concentrated. So if you</p> <p>25 look at the AMA study on health insurance markets, they</p> <p>Page 125</p>



<p>1 find that they are highly concentrated, that the 2 Herfindahl Index exceeds 2500 in several markets. 3 Similarly, if you look at data from the Kaiser Family 4 Foundation, which splits the market into individual, 5 small, and large groups, they also find highly 6 concentrated markets.</p> <p>7 And Aetna is, you know, the third largest 8 insurer. It's a dominant firm in several of these 9 markets. So Aetna is the number one or number two 10 insurer, according to the AMA study, in roughly 70 HMO 11 markets and about 100 PPO markets.</p> <p>12 So my opinion is that what this merger will do 13 is it will exacerbate the lack of competition in health 14 insurance markets. So we are already highly 15 concentrated. The merger might make these markets even 16 more concentrated.</p> <p>17 The reason why I think that might happen is 18 because CVS-Aetna, or the entity after the merger, is 19 going to control two key inputs for providing health 20 insurance, which are PBMs and pharmacies. So if you 21 have control over two key inputs, you have an incentive 22 to use these inputs to disadvantage health plans 23 competing with Aetna.</p> <p>24 And so if you increase the cost of these 25 inputs for these competing health plans, then these</p> <p>Page 126</p>	<p>1 disadvantage competing health plans. So maybe one the 2 things you can do, you know, the incentive would be 3 there that the PBM arm of CVS-Aetna might reduce the 4 pass through of rebate dollars to competing health 5 plans. So this will essentially increase the 6 prescription drug costs of competing health plans.</p> <p>7 The PBM arm of CVS-Aetna might not optimize 8 formulary design, and this might lead to changes in use 9 of prescription drugs and also changes in overall 10 healthcare costs. They might slow down claims 11 processing, or create, you know, other hurdles to 12 increase operating costs for competing health plans.</p> <p>13 They might not negotiate, so as I mentioned 14 earlier, one of the roles of the PBM is to negotiate 15 with pharmacies. So now if CVS-Aetna is negotiating 16 with its own pharmacy, CVS, they have an incentive to 17 not negotiate very hard, which would basically mean that 18 competing health plans will be paying higher in pharmacy 19 costs, and then the pharmacy arm of CVS-Aetna might 20 charge higher prices to competing health plans to 21 disadvantage them.</p> <p>22 So one of the issues is that suppose they do 23 this, maybe the competing health plans say we don't want 24 CVS-Aetna to be our PBM or our pharmacy provider and we 25 want to chose someone else.</p> <p>Page 128</p>
<p>1 completing health plans will experience an increase in 2 prescription drug costs. They might also experience an 3 increase in total healthcare costs because prescription 4 drug spending, or how well you manage your prescription 5 drug benefit, has a consequence for your total medical 6 cost.</p> <p>7 So if you design a formulary that is not 8 optimized, what will happen is that people might not 9 take their medications for chronic conditions and they 10 might end up in the hospital, increasing your medical 11 care costs.</p> <p>12 So the control of these two key inputs is not 13 only going to affect prescription drug costs, but might 14 also have spillovers on total healthcare costs. And if 15 total healthcare costs rise, it will probably lead to 16 increased premiums faced by consumers.</p> <p>17 And maybe some health plans or health plans 18 that are competing with Aetna recognize CVS-Aetna's 19 control over these two key inputs, and maybe they don't 20 enter the market or it reduces the level of competition, 21 they're disadvantaged in this market, so overall it 22 might lead to reduced competition in health insurance 23 markets.</p> <p>24 So to give you some examples of how, say, the 25 PBM arm or the pharmacy arm of CVS-Aetna might</p> <p>Page 127</p>	<p>1 And I feel the extent of if that would happen 2 is reduced by the fact that there isn't a lot of 3 competition in the PBM market. There are not a lot of 4 options available for competing health plans to go to 5 other large PBMs who might offer comparable services.</p> <p>6 And the other problem is the other large PBMs 7 also are owned by health plans, so then you're kind of 8 stuck with the same problem, that you are always stuck 9 with a PBM that is owned by a competitor.</p> <p>10 And finally, you know, CVS pharmacies, as we 11 heard today, are present everywhere. They have a 12 dominant position in the market. So even if you are not 13 happy with CVS pharmacies, a competing health plan might 14 not be able to exclude CVS pharmacies from their network 15 because patients would value having these pharmacies in 16 the network. So that gives CVS pharmacies, in some 17 sense, the market power to Advantage Aetna at the cost 18 of competing health plans.</p> <p>19 So one question you could ask is that suppose 20 they do this and they risk losing some PBM or pharmacy 21 customers, how strong are those incentives so that 22 potential loss and revenue from losing a PBM or pharmacy 23 customer, versus disadvantaging a competing health plan 24 and taking their customer as an insurance customer, 25 right?</p> <p>Page 129</p>

<p>1 So if I as a PBM or CVS-Aetna as a PBM doesn't 2 provide high quality service to competing health plans, 3 those competing health plans might drop CVS-Aetna as a 4 PBM, but CVS-Aetna might end up getting a customer from 5 that competing health plan to Aetna. So what would 6 those incentives look like?</p> <p>7 So if you just consider a hypothetical 8 customer who spends, say, on average \$10,000 a year -- 9 this is roughly what U.S. per capita spending on 10 healthcare is -- and let's say they spend about 10 11 percent of that on prescription drugs, so about \$1000 on 12 prescription drugs.</p> <p>13 So if you remember my numbers earlier, the PBM 14 net margin or net profit margin is about 22.3 percent. 15 So on the \$1000 of drug costs, the PBM is going to earn 16 roughly \$23 in profit. So if I lose this customer as a 17 PBM customer, I'm looking to lose about \$23 in profit.</p> <p>18 But if I gain this same customer as a health 19 insurance customer, then basically I'm going to make 20 about three percent on the total healthcare spending, 21 which is \$10,000. So three percent of \$10,000 is 22 roughly \$300, and I'm still going to be providing PBM 23 services to this customer because now they're a combined 24 entity, so I'm going to make another \$23 in PBM profits. 25 So getting one insurance customer is valued at roughly</p> <p>Page 130</p>	<p>1 insurer can exercise their market power to reduce 2 provider reimbursement. So to make sure that they clamp 3 down on hospital costs and physician costs and so on.</p> <p>4 But if you look at the evidence, the evidence 5 is that what the literature finds is, yes, there is some 6 evidence that larger insurers pay, you know, lower 7 prices to providers, but in net, higher market power in 8 the insurance industry means higher premiums for 9 consumers. So those savings from paying lower prices to 10 hospitals or physicians are not being passed on to 11 consumers in the form of lower premiums.</p> <p>12 Finally, we can kind of look at the potential 13 efficiencies in the health insurance market. So I think 14 one efficiency would be that now CVS becomes part of 15 Aetna, and therefore CVS has the incentive to be a 16 better PBM for Aetna. So right now they are separate 17 entities, CVS, the PBM, is more bothered about its 18 bottom line than, you know, what Aetna's bottom line 19 would be. But now when they become a combined entity 20 their incentives align, and therefore CVS might become a 21 better PBM for Aetna. It might optimize their formulary 22 design in a way as to lower total healthcare costs and 23 not just focus on the prescription drug costs.</p> <p>24 But the extent to which this happens and the 25 magnitude of the efficiencies or the savings will depend</p> <p>Page 132</p>
<p>1 \$323. Losing one PBM customer is valued at \$23. 2 So in some sense the incentives are there to 3 disadvantage competing health plans, even if it means 4 losing these \$23, because the gain on the other side is 5 pretty big, that if you get one insurance customer in to 6 your firm, that's going to be valued at \$323.</p> <p>7 So in other words, in this hypothetical 8 example one insurance customer is as valuable as 14 PBM 9 customers. So even if I lose 14 PBM customers and gain 10 one insurance customer, my profits remain unchanged.</p> <p>11 You can do the same calculation for the 12 pharmacy side of the market, and the numbers are fairly 13 similar that, you know, one insurance customer is as 14 valuable as nine pharmacy customers.</p> <p>15 And the reason this works is your net profit 16 margins are roughly similar in the insurance and the PBM 17 market, but as an insurance customer, you own that net 18 margin on the entire healthcare cost. But PBM and 19 pharmacy customers, you only earn the net margin on the 20 prescription drug cost and not the entire drug cost.</p> <p>21 So another argument here could be that, fine, 22 you know, maybe this merger might lead to some 23 anticompetitive effects, but maybe lack of competition 24 or higher concentration in the insurance market is good 25 for consumers. So one theory for that is that a big</p> <p>Page 131</p>	<p>1 upon whether CVS is performing kind of the key strategic 2 decisions for Aetna. Which is, are they in charge of 3 formulary design, are they the ones negotiating rebates 4 on behalf of Aetna and so on. So to the extent that 5 they are doing this, the savings would be big.</p> <p>6 But if you look at the 10K statement for 7 Aetna, which was filed with the Securities and Exchange 8 Commission, what that statement says is "We also perform 9 various pharmacy benefit management services for Aetna 10 pharmacy customers consisting of product development, 11 commercial formulary management, pharmacy rebate 12 contracting and administration, sales and the account 13 management, and precertification programs." And then 14 they go on to say that CVS performs certain 15 administrative functions related to PBM or related to 16 prescription drugs.</p> <p>17 So the key question is, you know, if Aetna is 18 already its own PBM, which is what they claim in their 19 SEC or their 10K filings, then this efficiency isn't 20 there. But to the extent that CVS is truly Aetna's PBM 21 right now and they are performing the core PBM 22 functions, then I think those efficiencies do exist.</p> <p>23 So based on the review of the prior 24 literature, what I conclude is that, in my opinion, the 25 potential costs of the merger, due to foreclosure in the</p> <p>Page 133</p>

1 insurance market, outweighed the potential efficiencies  
2 in the insurance market.

3 And here are some factors that led to this  
4 opinion. So the first was that CVS and Aetna, you know,  
5 will control two key inputs, PBMs and pharmacies, so  
6 they have an opportunity to disadvantage rival health  
7 plans.

8 CVS and Aetna have a dominant position in each  
9 one of these input markets, which means it's not going  
10 to be easy for competing health insurers to find other  
11 entities to provide these functions.

12 Third, the number of consumers who stand to  
13 lose from the mergers, so CVS has on its website, it  
14 claims that they serve about 94 million customers.  
15 Aetna on its website claims that they have about  
16 22 million subscribers. Which means maybe 22 million  
17 subscribers might benefit from this merger, but  
18 72 million subscribers who are basically CVS customers  
19 with competing health plans, might experience higher  
20 costs as a result of this merger.

21 Finally, the incentives are such that the gain  
22 from getting one insurance customer far exceeds the loss  
23 from losing a PBM and pharmacy customer, so their  
24 incentives are to kind of disadvantage competing health  
25 plans.

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1 So how might this, you know -- and if this  
2 happens, this will further strengthen the already  
3 dominant position CVS has, which is that they are the  
4 number one or number two pharmacy chain in 93 of the top  
5 100 markets in the U.S.

6 So how might this happen or what might some of  
7 these business practices look like? So CVS-Aetna  
8 pharmacies -- they could basically promote CVS-Aetna  
9 pharmacies or exclude competing pharmacies in outreach  
10 communication with CVS-Aetna insurance subscribers.

11 So as an insurance company you sometimes  
12 communicate about your pharmacy network with your  
13 beneficiaries or your subscribers, and maybe one thing  
14 you could do is highlight CVS pharmacies in bold font or  
15 give them more prominence in that communication while  
16 other competing pharmacies are hidden somewhere in the  
17 communication, and that might drive market share towards  
18 CVS pharmacies.

19 They could reduce reimbursement to competing  
20 pharmacies, and then maybe once they are under financial  
21 stress, subsequently buy them.

22 They could exclude competing pharmacies from  
23 the CVS-Aetna pharmacy network, so basically just say we  
24 won't send any of our subscribers to your pharmacies.

25 Or they could have preferred status for

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1 And as I said, to the extent that Aetna, as  
2 its SECs filings say is its on PBM, the potential  
3 efficiencies are minimal.

4 So now lets switch to the potential effect of  
5 competition in the pharmacy market.

6 So just like insurance markets, pharmacy  
7 markets are also highly concentrated. So CVS and  
8 Walgreens control about between 50 and 75 percent of the  
9 drugstore market in each of the countries 14 largest  
10 metro areas.

11 CVS has a dominant position in several  
12 markets. So according to, again their own SEC  
13 statements or 10K statement, they state that "We  
14 currently operate in 98 of the top 100 United States  
15 drugstore markets and hold the number one or number two  
16 market share in 93 of these markets." This is from  
17 their own filings with the Securities and Exchange  
18 Commission.

19 So now the argument here is similar, which is  
20 that the health insurance arm or the PBM arm of  
21 CVS-Aetna could disadvantage pharmacies competing with  
22 CVS by either excluding them from the pharmacy network  
23 or through other business practices, and this might hurt  
24 these competing pharmacies and therefore reduce the  
25 level of competition in the pharmacy market.

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1 CVS-Aetna pharmacies -- which was a question,  
2 Commissioner, you asked earlier -- which might be that  
3 consumer based lower cost sharing, if they go to  
4 CVS-Aetna pharmacies relative to other pharmacies.

5 So these are not just hypothetical examples.

6 In my expert report I cite a variety of lawsuits between  
7 pharmacies and PBMs where such conduct has been alleged.  
8 So these were all pulled from media reports where there  
9 were lawsuits where such conduct was alleged.

10 So one question might be that CVS is already  
11 the PBM for Aetna, so in some sense CVS CareMark, or the  
12 PBM, already has an incentive to favor CVS pharmacies,  
13 and then maybe this merger where CVS buys Aetna doesn't  
14 really affect that incentive.

15 And the counter argument to that would be that  
16 Aetna currently does not have the incentive to favor CVS  
17 pharmacies, but post merger that check disappears.  
18 Because right now if CVS CareMark tries to favor CVS  
19 pharmacies and that increases costs for Aetna, Aetna is  
20 going to object to it. But post merger, Aetna is part  
21 of the same entity, and that incentive disappears.

22 The other thing is that the vertical merger is  
23 more permanent than a contract, and therefore it  
24 eliminates competition that occurs when a contract needs  
25 to be renewed.

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35 (Pages 134 to 137)

<p>1 So right now there might be a contract with 2 CVS pharmacies, but if they don't like the terms or if 3 they feel CVS pharmacies are not providing value for 4 money, good quality care at low costs, they don't have 5 to renew the contract with CVS. But if there is a 6 merger, than that contract is no longer needed and it 7 becomes a more permanent deal.</p> <p>8 So this anticompetitive effect is going to be 9 larger in markets where Aetna has a dominant position. 10 So if Aetna controls, say, 50 percent of the market, 11 which it does in Anchorage Alaska, now independent 12 pharmacies in those markets are going to be really 13 worried because they might feel that 50 percent of the 14 market, or a large fraction of that 50 percent, might go 15 to CVS instead of to them.</p> <p>16 So the higher is Aetna's market share in a 17 market, the more worried would competing pharmacies be 18 about Aetna steering patients toward CVS pharmacies and 19 them losing business as a result.</p> <p>20 So now let's consider the potential 21 efficiencies in the pharmacy market. So in the 22 testimony today, as well as in other written testimony, 23 CVS argues that the merger will lead to lower healthcare 24 costs through integration of pharmacy and medical data. 25 So one protocol efficiency they talked about</p> <p>Page 138</p>	<p>1 costs.</p> <p>2 But I feel that Aetna can get this data 3 without a merger. So I think that would be the 4 exercise, to kind of analyze your pharmacy and medical 5 data together to optimize your medical benefit. So I 6 think they can get it without a merger, or maybe they 7 already have access to it through their existing 8 arrangement with CVS as their PBM.</p> <p>9 So again, based on this analysis, my opinion 10 is that the potential cost of the merger due to 11 foreclosure in the pharmacy market outweighs the 12 potential efficiencies in the pharmacy market.</p> <p>13 So the last market I consider is the PBM 14 market. So we have already covered that PBM markets are 15 also highly concentrated. Currently Aetna contracts 16 with CVS for some PBM services, it's unclear what the 17 exact nature of the contract is.</p> <p>18 So what will happen is if the merger happens, 19 this contract becomes more permanent or it about becomes 20 permanent, which basically means Aetna is not in the 21 market to contract for PBM services from other PBMs. So 22 this basically essentially contracts the size of the PBM 23 market that the third largest insurer in the U.S. is no 24 longer going to shop for PBM services because they have 25 their own in-house PBM. And this contraction in the</p> <p>Page 140</p>
<p>1 is providing data to pharmacists will allow them to 2 better counsel patients. But my understanding is that 3 Aetna, or typically a health insurer doesn't -- and this 4 kind of relates to your question earlier -- a health 5 insurer doesn't have access to electronic health 6 records. Typically what a health insurer has access to 7 is claims or billing data.</p> <p>8 I feel that data is not enough to, even if 9 that data is provided to pharmacists, that's not enough 10 information for them to better counsel patients. What 11 the pharmacist would need is the electronic health 12 records from the medical providers, and for that what 13 you need is some sort of data use or data sharing 14 agreement with the electronic health, you know, with the 15 medical providers to share their electronic health 16 records with CVS, and I don't see how this merger helps 17 with that. So given that I feel the potential for 18 efficiencies is reduced.</p> <p>19 Another efficiency is that the integration of 20 pharmacy and health plan data might lead to better 21 benefit design. So ultimately as a health plan what you 22 care about is your total healthcare cost, and now if you 23 have access to pharmacy data and you use some fancy 24 analysis, you might be able to tweak, you know, which 25 drugs to cover as to reduce your overall healthcare</p> <p>Page 139</p>	<p>1 size of the market could, you know, reduce incentives to 2 enter the PBM market for potential entrants.</p> <p>3 The potential entrants might also be worried 4 that most of the PBMs they will not competing with will 5 also be integrated with a health insurer. So Humana has 6 its own PBM. Aetna will have its own PBM. United will 7 have its own PBM. So a new PBM entrant might worry that 8 they not only need no enter the PBM market, but the 9 health insurance market both at the same time, and that 10 might be a big hurdle to cross.</p> <p>11 So result of this, we might experience less 12 entry in the PBM market, and therefore reduced 13 competition in the PBM market.</p> <p>14 So now just kind of combining the conclusions 15 from the analysis of the PBM, health insurance, and 16 pharmacy market, what I conclude is that within each of 17 these specific markets, the insurance, pharmacy, and PBM 18 market, in which the merger is likely to have 19 anticompetitive effects, there are no potential benefits 20 of sufficient magnitude or certainty that would outweigh 21 the anticompetitive effects of the merger.</p> <p>22 Thank you very much. 23 COMMISSIONER JONES: Thank you. 24 So now we'll go to Ms. Ross -- Dr. Diana -- 25 Moss, I'm sorry. Ross is the musical artist. Moss is</p> <p>Page 141</p>

<p>1 the antitrust expert.</p> <p>2 Ms. Moss, thank you for joining us</p> <p>3 telephonically, and we would welcome the chance to hear</p> <p>4 from you now.</p> <p>5 MS. MOSS: Very good. Thank you very much,</p> <p>6 Commissioner Jones. It's an honor to be testifying</p> <p>7 virtually here today, and unfortunately I do not have a</p> <p>8 good singing voice, so I'll have to stick to the</p> <p>9 economics and the antitrust as my contribution.</p> <p>10 You know, at this point in the lineup, you</p> <p>11 know, I would be repeating a lot of what you have heard</p> <p>12 from previous witnesses. So I'm going to do some fancy</p> <p>13 footwork and sort of retool my presentation to hit on</p> <p>14 some of the high points that you have already heard, and</p> <p>15 themes, but also to emphasize what we think are</p> <p>16 important points.</p> <p>17 So just by way of introduction, the American</p> <p>18 Antitrust Institute is an independent nonprofit</p> <p>19 research, education, and advocacy organization. We've</p> <p>20 been around for 20 years --</p> <p>21 COMMISSIONER JONES: Ms. Moss, I should have</p> <p>22 said this at the front end because you missed it, but</p> <p>23 we've got a court reporter, and she's trying to capture</p> <p>24 all of this, so just a little bit slower delivery.</p> <p>25 Thank you.</p> <p>Page 142</p>	<p>1 at either level, or any of those three levels, and it</p> <p>2 would transform that industry to a very, very different</p> <p>3 profile where we have integrated PBMs and health</p> <p>4 insurers, particularly with Express Scripts and Cigna</p> <p>5 waiting in guilty the wings. We already have United</p> <p>6 Healthcare and Optum RX in the market.</p> <p>7 Together, if all of those three hypothetically</p> <p>8 were to become vertically integrated or to solidify that</p> <p>9 landscape, we would have a fundamentally different</p> <p>10 market structure to deal with. It would raise the bar</p> <p>11 on entry, it would weaken incentives to compete</p> <p>12 dramatically, and it would discourage innovative,</p> <p>13 disruptive business models.</p> <p>14 So I want to talk about three things. Give</p> <p>15 some important facts that set the table for how we look</p> <p>16 at these vertical mergers and why we are concerned about</p> <p>17 their effects on competition and consumers.</p> <p>18 I want to just hit the high points again on</p> <p>19 why the merger raises serious concerns about forecloser</p> <p>20 or the exclusion of rivals at both the upstream PBM and</p> <p>21 retail pharmacy levels, but also in health insurance.</p> <p>22 I want to talk about why the merger would</p> <p>23 actually facilitate anticompetitive coordination between</p> <p>24 players in the resulting market, and I want to debunk or</p> <p>25 discount any claims that this merger would produce</p> <p>Page 144</p>
<p>1 MS. MOSS: I'll slow it down. Very good.</p> <p>2 Thank you.</p> <p>3 So the American Antitrust Institute is an</p> <p>4 independent nonprofit research, education, and advocacy</p> <p>5 organization devoted to promoting competition and</p> <p>6 protecting consumer welfare.</p> <p>7 My testimony here today is based on a letter</p> <p>8 that AAI sent to the U.S. Department of Justice</p> <p>9 Antitrust Division on March 26th, 2018 urging the</p> <p>10 Division to block the proposed merger of CVS and Aetna.</p> <p>11 I will explain our reasoning in that letter in</p> <p>12 summary form today.</p> <p>13 So, you know, at a high level, let's go up to</p> <p>14 ten thousand feet and look at what this deal really</p> <p>15 presents to competition and to the American consumer.</p> <p>16 It pairs up the number one retail pharmacy</p> <p>17 chain and one of the two largest PBMs in the nation with</p> <p>18 the third largest health insurer in the country. So it</p> <p>19 is a massive, massive, combination of PBM and retail</p> <p>20 pharmacy services and products with a leading health</p> <p>21 insurer.</p> <p>22 It would entail fundamental restructuring of</p> <p>23 the industry as we know it from largely nonintegrated</p> <p>24 PBMs and retail pharmacies and nonintegrated insurers to</p> <p>25 a, where we have more open competition and easier entry</p> <p>Page 143</p>	<p>1 efficiencies sufficient to overwhelm the anticompetitive</p> <p>2 effects.</p> <p>3 So before that, and certainly in light of what</p> <p>4 has happened in the last two weeks in the recent</p> <p>5 district court decision in AT&amp;T-Time Warner -- which is</p> <p>6 also a vertical merger -- and presents one of the very</p> <p>7 same issues that is at issue in CVS-Aetna, I want to say</p> <p>8 that is not a good predictor of an outcome in this</p> <p>9 particular case.</p> <p>10 Lest anyone, any sort of pro merger, pro</p> <p>11 consolidation proponents out there rely on this decision</p> <p>12 to make their case to the antitrust authorities or to</p> <p>13 state regulatory agencies, we would really, really</p> <p>14 discourage that. We have a very different fact pattern</p> <p>15 here -- and by the way, for those of you not following</p> <p>16 the case, the district court found in favor of the</p> <p>17 defendants against the government in attempting to</p> <p>18 challenge that deal.</p> <p>19 Very different fact pattern here. Very</p> <p>20 significant concerns about the role of market</p> <p>21 concentration and the dominance of the firms involved in</p> <p>22 this transaction, and the likely anticompetitive and</p> <p>23 anticonsumer effects.</p> <p>24 We also have an established record of a lack</p> <p>25 of transparency in prescription drug pricing and rebates</p> <p>Page 145</p>

<p>1 involving the PBMs, and deliberate attempts to shape and 2 control competition in the PBM and retail pharmacy 3 space.</p> <p>4 So how important is this merger? It is 5 vitally important and should get very serious scrutiny 6 at all levels. Pharmaceutical expenditures account for 7 17 percent of total healthcare outlays in the U.S. PBMs 8 manage prescription drug benefits for 95 percent of 9 Americans with coverage.</p> <p>10 So we are dealing with a potentially very 11 harmful merger that deserves particularly intense 12 scrutiny for the benefit of promoting competition and 13 protecting consumers.</p> <p>14 So let's talk about concentration. You've you 15 heard a lot about that from very expert witnesses here. 16 Why is concentration and the market shares of these 17 players so important? The reason why is because it sets 18 the table, it lays out a landscape for why we should be 19 so concerned about the effect of this merger, a vertical 20 merger, in pairing up PBM and retail pharmacy players 21 with health insurers and fundamentally changing their 22 incentives, pre merger to post merger, not to engage in 23 dealing with all comers, but to engage in exclusionary 24 conduct that would make it harder for smaller PBMs to 25 compete and retail pharmacies to compete, particularly</p> <p>Page 146</p>	<p>1 sponsors, whoever the customer is, to go look around for 2 choice and alternatives to a firm that might be 3 exercising market power.</p> <p>4 This dominance, particularly in PBM, gives CVS 5 the ability to influence, have a tremendous amount of 6 influence over which drugs are dispensed, what sources 7 they are dispensed from. They have protected positions 8 in serving their clients because once subscribers are 9 in, they are limited to those affiliated pharmacy 10 services.</p> <p>11 So we should pay great attention to the 12 landscape here and the high levels of concentration and 13 market dominance associated with these two players that 14 are proposing to create a vertically integrated firm.</p> <p>15 So moving on to how the merger can harm 16 competition and consumers. I'm not going to spend a lot 17 of time on this. It's been explained very, very well. 18 But there are really two ways or two channels through 19 which combining these two companies will fundamentally 20 change incentives pre-to-post merger, that could 21 disadvantage rival insurers in the downstream health 22 insurance markets, and impede competition down there, 23 but also disadvantage smaller PBMs and independent 24 pharmacies in the upstream markets up there.</p> <p>25 So there's two theories. One is what we call</p> <p>Page 148</p>
<p>1 the independents, and also to squelch or to stifle 2 competition in the health insurance market.</p> <p>3 So insurance markets are very concentrated. 4 The largest four insurers account for 83 percent of the 5 national market. Markets are defined locally in large 6 part for health insurance as Professor Greaney pointed 7 out. 70 percent of locally defined HMO, PPO, POS, and 8 exchange markets are highly concentrated. That means 9 there's not many players down there. There's not many 10 choices for planned sponsors and subscribers.</p> <p>11 Aetna is the first or second largest insurer 12 in numerous metropolitan statistical areas. The DOJ 13 successfully blocked the mergers of Anthem-Cigna and 14 Aetna-Humana, showing that the merger would result in 15 very highly concentrated markets. Those were both wins 16 by the government in preventing those mergers from 17 moving forward.</p> <p>18 Turning to PBMs and retail pharmacy, CVS has a 19 25 percent national market share. Express Scripts has a 20 24 percent national market share. Combined they account 21 for 50 percent of the market, the PBM market. The three 22 largest PBMs control 85 percent of the market. That is 23 not a lot of competition. It is not a lot of choice, 24 either at the health insurance level or at the PBM level 25 and retail pharmacy level for consumers, for planned</p> <p>Page 147</p>	<p>1 input foreclosure, which is essentially enhanced 2 incentives, and certainly the ability for the merged 3 company to cut off or frustrate rival health insurers 4 access to CVS products and services.</p> <p>5 So premerger, CVS has pretty strong incentives 6 to deal with all health insurers. They're not 7 integrated, they're standalone, but post-merger there's 8 a fundamental change. The company now controls an 9 essential, dominant PBM by combining the insurer with 10 the PBM. It's a critical input for rival health 11 insurers.</p> <p>12 So the combined company now has enhanced 13 incentives through greater bargaining leverage to 14 frustrate rival and insurers access to CVS products and 15 services. They could raise their costs, they could cut 16 them off, and they could do that through any number of 17 conditions.</p> <p>18 They could develop formularies, for example, 19 that don't include important drugs that are in demand by 20 subscribers. They could refuse to provide transparency 21 about actual costs of drugs or payments or rebates they 22 get from manufacturers. They could offer pharmacy 23 networks that don't provide important options, such as 24 independent specialty pharmacies, or they could force 25 rival insurers into CVS CareMark mail order services --</p> <p>Page 149</p>

<p>1 we have already seen that happen.</p> <p>2 They could gather information on subscribers</p> <p>3 and drug spend for rival insurers and target those</p> <p>4 insurer's customers in ways that would impair their</p> <p>5 ability to compete. Or they could simply decline to</p> <p>6 fill prescriptions for rival insurer's enrollees. So</p> <p>7 there's absolutely any number of mechanisms through</p> <p>8 which the merged company would act on its greater</p> <p>9 incentives to make it more difficult for rival insurers</p> <p>10 to compete.</p> <p>11 So the key here to understanding why market</p> <p>12 concentration is so important and is such a fulcrum or a</p> <p>13 link between concerns over anticompetitive effects is</p> <p>14 because health insurers have very few options, very few</p> <p>15 options to switch to other PBMs, right? The two largest</p> <p>16 PBMs account for 50 percent of the PBM market, right?</p> <p>17 So if you're a rival health insurer and you've</p> <p>18 just been cut off by CVS or it's more expensive now for</p> <p>19 you to deal with CVS, you go searching around for a</p> <p>20 rival PBM. Well, smaller PBMs don't have the kind of</p> <p>21 bargaining power, they don't have the sophisticated drug</p> <p>22 management programs. They are not good options. They</p> <p>23 are not good substitutes for these health insurers</p> <p>24 searching around to avoid the discriminatory or the</p> <p>25 exclusionary conduct.</p> <p>Page 150</p>	<p>1 These smaller PBMs don't have the scale and</p> <p>2 the scope that the larger PBMs do to negotiate for</p> <p>3 rebates, other network services, they are particularly</p> <p>4 exposed to restrictive conduct, to exclusionary conduct,</p> <p>5 as are the independent pharmacies, if we're talking</p> <p>6 about the retail pharmacy market -- which are very</p> <p>7 important community institutions and provide services,</p> <p>8 particularly for seniors.</p> <p>9 The result of customer foreclosure would be</p> <p>10 higher prescription drug prices, lower quality, and the</p> <p>11 less innovation.</p> <p>12 The last concern about anticompetitive effects</p> <p>13 is that the merger creates incentives not only to</p> <p>14 exclude rivals, but for the companies to coordinate</p> <p>15 instead of to compete.</p> <p>16 So there's two possibilities here. Let's say</p> <p>17 CVS deals with Aetna, obviously as its integrated</p> <p>18 affiliate, but it also continues to serve other rival</p> <p>19 health insurers. So now CVS has lots of information</p> <p>20 about rival health insurers' subscribers. They can take</p> <p>21 that information on drug spend and on preferences and</p> <p>22 all sorts of important customer information and they</p> <p>23 can -- it circulates within the company, within the</p> <p>24 integrated CVS-Aetna infrastructure, now they have</p> <p>25 critical information on arrivals, customers. That can</p> <p>Page 152</p>
<p>1 The bottom line is it risks, this type of</p> <p>2 strategy risks higher insurance premiums, lower quality</p> <p>3 services, and less innovation.</p> <p>4 All right, turning quickly now to the other</p> <p>5 foreclose theory, which is customer foreclosure, which</p> <p>6 you just heard about, affects the PDM market. So it</p> <p>7 could disadvantage rival PBMs and independent</p> <p>8 pharmacies, right, through what we call customer</p> <p>9 foreclosure.</p> <p>10 So pre merger Aetna has great incentives to</p> <p>11 deal with rival PBMs as a standalone insurer. Post</p> <p>12 merger, now the company controls an important customer,</p> <p>13 right, this vertical integrated company controls an</p> <p>14 important customer.</p> <p>15 The company therefore has enhanced incentives</p> <p>16 and greater bargaining leverage to frustrate rival PBMs</p> <p>17 by making it difficult for them to access Aetna as a</p> <p>18 potential customer. They, too, can impose any number of</p> <p>19 conditions. They can drive down dispensing fees and</p> <p>20 delay reimbursement to smaller rival PBMs. They can</p> <p>21 cherrypick profitable prescriptions and enforce</p> <p>22 take-it-or-leave-it contracts with independents, right?</p> <p>23 Aetna can refuse to grant an affiliation for a rival PBM</p> <p>24 to serve their insured members -- which is really</p> <p>25 critical for insuring prescription drug coverage.</p> <p>Page 151</p>	<p>1 facilitate price fixing, it can facilitate market</p> <p>2 allocation, and any number of other ways that would lead</p> <p>3 to coordination as opposed to hardnosed competition.</p> <p>4 The other way they can ultimately coordinate,</p> <p>5 is if these other vertical mergers actually go through</p> <p>6 and we see a vertically integrated Express Script Cigna,</p> <p>7 if CVS-Aetna goes through, we have United Healthcare and</p> <p>8 Optum, we would have three vertically integrated PDM</p> <p>9 insurer systems transforming the industry away from its</p> <p>10 current structure to a decidedly, decidedly</p> <p>11 anticompetitive structure.</p> <p>12 Having three massive, vertically integrated</p> <p>13 platforms creates very strong incentives for those firms</p> <p>14 to align themselves on various policies, to engage in</p> <p>15 coordination and tacit coordination, tacit conclusion,</p> <p>16 on any number of issues. And that would prevent the</p> <p>17 entry of more innovative PBMs, smaller PBMs, more</p> <p>18 innovative or disruptive business models that would like</p> <p>19 to come in and enter the market.</p> <p>20 So in sum, the merger creates significant</p> <p>21 concerns about exclusionary conduct post merger, both in</p> <p>22 the PDM and the health insurance market, but it also</p> <p>23 creates very significant concerns about an</p> <p>24 anticompetitive coordination as a result.</p> <p>25 And then finally, I just want to point out</p> <p>Page 153</p>

<p>1 that there has been little evidence that previous 2 mergers in this space has resulted in any substantial 3 benefits. So we have to look skeptically at the record 4 evidence and merger retrospectives that show that. 5 The more anticompetitive a merger is, the 6 higher is the burden to though -- and the burden falls 7 on the companies -- to show any claimed efficiencies 8 from their deal, like elimination of double margins, 9 coordination effects, all the kinds of things you've 10 heard about today, the higher is the burden to show that 11 those efficiencies will countervail anticompetitive 12 effects. That is a very, very tall order. 13 Nor have the companies shown or demonstrated 14 that they need this merger to achieve those benefits, 15 versus contracting, engaging in really creative, 16 innovative contracting at arm's length with a PBM or 17 with a health insurer to achieve those types of 18 benefits. 19 So we're not convinced these efficiencies are 20 merger specific. We are not convinced that they are 21 actually cognizable or verifiable and that they will 22 actually occur. 23 And I would point out that the record evidence 24 on efficiencies is really burgeoning. The management 25 consulting literature shows, a big study by Mackinzie</p> <p>Page 154</p>	<p>1 COMMISSIONER JONES: So with the indulgence of 2 this panel, I know that we may lose Dr. Scheffler 3 because he has to go, but if the others could remain and 4 give the court reporter a break, and then we'll resume 5 for the last witness in this panel in ten minutes. 6 Thank you. 7 (Off the record.) 8 COMMISSIONER JONES: So we're going to resume 9 the hearing, and ask folks if they can take their seats, 10 and we have one more witness on this panel, and that's 11 Dr. Lawton Burns, and we want to welcome you and thank 12 you for joining us as well. 13 Thanks for letting us take a little recess in 14 advance of your testimony. 15 MR. MORIARTY: 16 MR. BURNS: Thank you, Commissioner, for 17 allowing me to have the opportunity to testify. I come 18 to you today from the temple of capitalism out on the 19 east coast, The Wharton School. It also happens to be 20 the President's alma mater, so hopefully you won't hold 21 that against me. 22 Like our prior speakers, there's some 23 disclosures I need to make. My work was supported by 24 the AMA, but it doesn't reflect their views. 25 Just by way of background, I'm a professor at</p> <p>Page 156</p>
<p>1 some years ago, shows 70 percent of mergers don't prove 2 up the cost savings. And in a vertical merger -- which 3 is especially difficult and complex given that you're 4 integrating two very different organizations, there are 5 limitations on managerial competence and other 6 factors -- it is a very, very tall order to expect 7 efficiencies to materialize, to be merger specific, and 8 to actually overwhelm these anticompetitive effects. 9 And given the market dominance of these 10 players and the high levels of concentration and the few 11 substitutes that are available out there, I don't think 12 we would ever see any cost savings passed on to 13 consumers, insurers, and ultimately to their 14 subscribers. 15 So AI's position is the most effective remedy 16 here is to block the merger outright. 17 Thank you. 18 COMMISSIONER JONES: Thank you very much, 19 Dr. Moss. 20 Let me check in with the court reporter and 21 see how she's doing. 22 COURT REPORTER: It's been close to two hours. 23 COMMISSIONER JONES: So perhaps we should take 24 ten minutes. 25 COURT REPORTER: Ten minutes is great.</p> <p>Page 155</p>	<p>1 the Wharton School. Unlike the other speakers, I'm not 2 an economist or an attorney, I'm a behavioral scientist, 3 assist, so I think that I'm probably here for comic 4 relief given everything we've heard about foreclosure 5 and Herfindahl indexes. 6 I'm a professor of healthcare management, 7 study of management strategy in the healthcare system. 8 I've done much of my work over the last 30 years on 9 vertically integrated combinations in the healthcare 10 industry. 11 I teach the core course at the Wharton School 12 on the entire healthcare industry. I have done that for 13 20 years. Prior to that I taught intro to the 14 healthcare system at other universities for 15 years 15 before that. So I've been teaching an intro course on 16 the healthcare system for about 35, 36 years. 17 I have learned two things by having to cover 18 the entire healthcare system. First, as the President 19 himself acknowledged last year, healthcare is pretty 20 complex. The second thing is, and pardon my French, but 21 this industry is full of BS, and so you need to have a 22 good BS detector when you study what goes on in the 23 industry, and I spend a lot of my time confronting a lot 24 of this. 25 The thrust my testimony is that other</p> <p>Page 157</p>



<p>1 witnesses have opined on the mergers anticompetitive 2 effects. I'm not an economist, so I will not be talking 3 about anticompetitive effects. Where I come in is when 4 something is found or suspected to be anticompetitive. 5 I will argue here today that the merger fails to deliver 6 any offsetting or compensating benefits that this might 7 nevertheless justify the merger.</p> <p>8 I'm often asked to testify in antitrust cases 9 about the possible presence of such offsetting benefits. 10 For the last 15 years I have worked for the Department 11 of Justice, the Federal Trade Commission, and several 12 State Attorney Generals on these things, and from what I 13 have been able to glean based on my experience in the 14 healthcare industry, looking at this specific merger, my 15 knowledge of the different sectors that are being 16 combined here, I do not think that there is any evidence 17 for the supposed benefits flowing from this merger.</p> <p>18 In particular what my comments will focus on 19 is one aspect of the operations of the projected merger, 20 and that's the retail clinics. So that's what the bulk 21 of my remarks will focus on.</p> <p>22 So just some general observations. First, as 23 Diana Moss recognized, the proposed merger is based on a 24 corporate strategy of vertical integration. Having 25 studied this for 30 years, I can tell you there is no</p> <p>Page 158</p>	<p>1 from this vertical merger.</p> <p>2 Put the consumer at the center of the 3 healthcare delivery system. Remake the consumer 4 healthcare experience. Engage and empower consumers. 5 Help consumers achieve their best health. Improve the 6 coordination of care. Address simultaneously chronic 7 illness, primary care, and prevention. And also 8 simultaneously solve the three problems that have vexed 9 our healthcare system since the 1930s: rising costs, 10 unsure quality, and poor access to care. What we call 11 the iron triangle of care.</p> <p>12 If the two parties in this proposed merger are 13 able to pull all these things off, they deserve the 14 Nobel prize. If they delivered on any one of those, I 15 would be willing to put them up and nominate them for 16 the prize, but these things are incredibly difficult to 17 do, and we haven't really done any of these things to 18 date.</p> <p>19 The reason why I'm skeptical of their ability 20 to do so, is you look at where these parties play in the 21 healthcare system -- so I have a chart up here of a 22 portrayal of the healthcare system. There are basically 23 five verticals here.</p> <p>24 On the left you have the people who pay for 25 healthcare, that's government, employers, and ultimately</p> <p>Page 160</p>
<p>1 prima face evidence for consumer welfare benefits 2 flowing from a strategy of vertical integration, so the 3 burden is on the people doing it to demonstrate that.</p> <p>4 In fact, in the healthcare industry the 5 strategy of vertical integration usually leads to higher 6 prices, higher cost, and higher utilization, and 7 sometimes it also results in greater market power. So 8 there are grounds to be cautious, if not suspicious, of 9 vertical mergers.</p> <p>10 Based on the research evidence, one cannot 11 assume that the consumer benefits will automatically 12 flow from such a vertical merger in the healthcare 13 industry, and there is oftentimes a disconnect between 14 the rationales espoused by the company executives who 15 engage in vertical integration versus those enunciated 16 in and academic theory and research. And based on my 17 experience having studied this for 30 years, such 18 disconnects often portend strategic failures to deliver 19 on the promised benefits.</p> <p>20 Now some specific conclusions. First, one 21 must examine the specific merger benefits advanced by 22 the parties. And I have gone through the prior 23 testimony of the witnesses from Aetna and CVS, and I was 24 here this morning listening to what they said, and I'm 25 just going to reiterate some of the promised benefits</p> <p>Page 159</p>	<p>1 individuals.</p> <p>2 In the middle you have the providers of 3 healthcare, hospitals and doctors which count for 4 53 percent of all healthcare expenditures.</p> <p>5 And on the right you have the producers of 6 healthcare products, the technology sectors, pharma, 7 biotech, medical device.</p> <p>8 And so separating the payers, providers, and 9 producers are two sets of intermediaries, the 10 insurers -- the second box from the left -- and then the 11 distributors -- the second box from the right.</p> <p>12 Not what's instructive is if you look at where 13 Aetna and CVS play in this entire healthcare value 14 chain -- I have put in red where Aetna-CVS CareMark and 15 CVS pharmacies play here -- these are not typically 16 considered to be the levers to change the healthcare 17 system and deliver on cost, quality, and access.</p> <p>18 They are certainly not prime movers to improve 19 social determinants of health, population health, or 20 public health. They are not prime movers to really do 21 what's needed to improve the healthcare system, that's 22 to improve the economy, which finances the healthcare 23 system.</p> <p>24 And lastly they are not really fundamentally 25 positioned to change the behaviors of the population</p> <p>Page 161</p>

<p>1 that is the most costly population to deal with in the 2 healthcare system, which we call the poly-chronics. 3 Those are the chronically ill patients who have multiple 4 chronic conditions.</p> <p>5 Roughly 20 percent of the Medicare population 6 accounts for three-quarters of all Medicare 7 expenditures. It's like the Pareto principle, 20 8 percent explains 80 percent. That 20 percent has five 9 or more chronic conditions such as chronic obstructive 10 pulmonary disease, diabetes, asthma, hypertension, 11 depression, and other things, and there's nothing in any 12 of the documents that I have seen that suggests that 13 anybody, let alone in the proposed merger parties, have 14 an ability to address the needs of that population.</p> <p>15 So quickly, I'll just give you some supporting 16 arguments for my general conclusions.</p> <p>17 First off, this merger is what I call a 18 defensive merger. The two parties to this merger are 19 merging for defensive reasons, primarily not to deliver 20 on all the supposed promises that I enumerated.</p> <p>21 First part, CVS has been losing business to 22 Walgreens, its major competitor, and CVS also feared the 23 potential entry of Amazon into the pharmacy business. 24 Both of those things have catalyzed the merger from 25 their end.</p> <p>Page 162</p>	<p>1 clinics has been stagnant for the last three years, and 2 that stagnant growth also characterizes the pharmacy 3 industry in which you find these retail clinics. So 4 this is not a booming industry. It's not a booming 5 industry, and therefore that's one reason why it's not 6 going to disrupt anything.</p> <p>7 Secondly, retail clinics supply only 8 one-to-two percent of primary care, so it's not a really 9 big player in the primary care area. The MinuteClinics, 10 part of CVS pharmacies, generate less than 1 percent of 11 CVS' retail pharmacy dispensing revenues. Oftentimes 12 these retail clinics are unprofitable.</p> <p>13 And what most of the players in the retail 14 clinics industry have found, is they are unable to 15 effectively cross-sell products that people would come 16 to a pharmacy for, such as drugs, visits to the 17 MinuteClinic, or what we call HABA or Health and Beauty 18 Aids. And so people usually go to a pharmacy for one of 19 those, but not necessarily to get all three of them at 20 the same time.</p> <p>21 A third set of supporting arguments is that 22 these retail clinics have major shortcomings as a 23 provider of healthcare. First off, there is documented 24 evidence that the retail clinics fail to serve the 25 underserved. And that was a core principle of the</p> <p>Page 164</p>
<p>1 For its part, Aetna failed to grow, which is a 2 major thing. And they failed to grow because its merger 3 with Humana was blocked by the Department of Justice in 4 early 2017. And Aetna needed that merger to grow into 5 the Medicare Advantage market, which is one of the major 6 growing markets. So it was foreclosed on growth there.</p> <p>7 Secondly, Aetna has been watching as its major 8 competitor, United Healthcare, has been building up its 9 delivery system, which includes lots of physicians, 10 surgery centers, urgent care centers, and things like 11 that. So Aetna is looking for some way to sort of 12 counterbalance what its prime competitor has been doing. 13 In this case it's trying to acquire a chain of retail 14 clinics, which you find in CVS.</p> <p>15 Second set of supporting arguments. The 16 retail clinics which are part of the CVS pharmacy have a 17 lot of hype and B.S. surrounding them. Back in, right 18 before 2000 Clay Christensen, very famous professor at 19 the Harvard Business School, published a book on 20 disruptive innovation in healthcare. He held out three 21 exemplars of that disruptive innovation in healthcare, 22 one of them was retail clinics, that disruption never 23 happened.</p> <p>24 First the forecasted growth of retail clinics 25 never came to pass. In fact the growth of retail</p> <p>Page 163</p>	<p>1 theory of disruptive innovation.</p> <p>2 So the retail clinics have studiously avoided 3 poor neighborhoods, rural areas, low income areas, and 4 instead they have gone after the higher income, higher 5 insured populations.</p> <p>6 Secondly, they have failed to target the 7 chronically ill, and that's because they go after the 8 minor acute care thing, scrapes, bruises, people needing 9 vaccines. This is not where you're going to find the 10 poly-chronics coming to get their chronic illness care 11 taken care of.</p> <p>12 Third, they do not have the personnel and the 13 capacity to address chronic illness. So with all due 14 respect to what I heard this morning, these are not 15 chronic care sites.</p> <p>16 They have an inability to succeed in wellness 17 and prevention. And I need no further than to point out 18 reports that have come out by the Rand Corporation out 19 here, just how unsuccessful corporate wellness and 20 prevention efforts have been.</p> <p>21 Typically the only people who enroll in 22 wellness and prevention efforts are voluntary enrollees 23 who are the worried well, who just want to take better 24 care of their health. They are not the poly-chronics 25 and the people who are underwater both physically and</p> <p>Page 165</p>

<p>1 financially.</p> <p>2 Related to this, the clinics have an inability</p> <p>3 to conduct medication therapy management which</p> <p>4 oftentimes requires ongoing supervision by a physician.</p> <p>5 Maybe working with a pharmacist is a good thing, but</p> <p>6 medication therapy management has been something that's</p> <p>7 been a real thorny problem that has not been addressed,</p> <p>8 and I doubt that's going to be taken care of by a</p> <p>9 MinuteClinic inside of a retail pharmacy.</p> <p>10 In general, the community health center</p> <p>11 movement has been a failure in this country. It's also</p> <p>12 been a failure in other countries. I have written books</p> <p>13 on India's healthcare system, China's healthcare system.</p> <p>14 All of these countries would like to have a more</p> <p>15 community health center base to their healthcare system,</p> <p>16 nobody has bothered to pull it off, and we have failed</p> <p>17 at this since the 1960s.</p> <p>18 Finally, these clinics have a limited ability</p> <p>19 to reduce cost and improve quality. There is just no</p> <p>20 evidence that these things can improve quality, and</p> <p>21 because they are treating the minor conditions, they are</p> <p>22 not going to make a dent in the rising cost the</p> <p>23 healthcare. And because they're dealing with people who</p> <p>24 are coming in for minor conditions, they're not going to</p> <p>25 be addressing the costs of specialty pharmaceuticals,</p> <p>Page 166</p>	<p>1 So one of your points was that based on a SEC</p> <p>2 or other financial filing by Aetna, that it was already</p> <p>3 providing some level of PBM services, and I believe it</p> <p>4 was your argument that, therefore, there would not be</p> <p>5 much benefit associated with the merger.</p> <p>6 But then later on you make a different point,</p> <p>7 which is that Aetna is relying on CVS CareMark for</p> <p>8 pharmacy care benefit services, and that the merger may</p> <p>9 result in anticompetitive effects because of that</p> <p>10 reliance.</p> <p>11 So those two points seem to be in conflict,</p> <p>12 and I'm wondering, if I'm making myself understandable,</p> <p>13 if you might explain why they are not in conflict if</p> <p>14 they're not.</p> <p>15 MR. SOOD: Sure. Based on Aetna's SEC's</p> <p>16 filings, both are true, that Aetna claims to be</p> <p>17 providing PBM services to its own subscribers, and at</p> <p>18 the same time they have a contract with CVS to provide</p> <p>19 certain other PBM services.</p> <p>20 So CVS is the PBM for Aetna and Aetna is the</p> <p>21 PBM for Aetna. And the question who's doing what part</p> <p>22 of the PBM services is unclear. So my argument was if</p> <p>23 Aetna is providing its own core PBM services -- which is</p> <p>24 negotiating with pharmaceutical firms, deciding which</p> <p>25 drugs are in the formulary, the cost sharing and so</p> <p>Page 168</p>
<p>1 which are the fastest growing portion of expenditures in</p> <p>2 the pharmacy area.</p> <p>3 Then the last thing I'll say is that CVS</p> <p>4 operates roughly 10,000 pharmacies in this country, but</p> <p>5 they only operate about 1000 or 1100 retail clinics. So</p> <p>6 CVS itself does not possess the capability to roll out</p> <p>7 this retail clinic concept in its pharmacies. They're</p> <p>8 going to have to invest an awful lot of money in what,</p> <p>9 to date, has been a money losing operation.</p> <p>10 Thank you so much.</p> <p>11 COMMISSIONER JONES: Thank you very much.</p> <p>12 I just had one or two questions. Let me start</p> <p>13 first with our last witness.</p> <p>14 I guess the slide supporting arguments No. 2,</p> <p>15 where you address the success of retail clinics</p> <p>16 generally. There's a bullet "May supply only one or two</p> <p>17 percent of all primary care."</p> <p>18 Is that measured -- well, let me just ask:</p> <p>19 How is that measured? Is it by volume of incidents and</p> <p>20 provision of primary care or revenues of primary care or</p> <p>21 some other --</p> <p>22 MR. BURNS: It's encounters.</p> <p>23 COMMISSIONER JONES: It's encounters. Okay.</p> <p>24 The other question that I had was for</p> <p>25 Professor Sood.</p> <p>Page 167</p>	<p>1 on -- so to the extent it's already doing all these core</p> <p>2 functions, then merging with CVS does not the create</p> <p>3 much sufficiency.</p> <p>4 Because maybe CVS is just providing</p> <p>5 administrative services related to being a PBM, so</p> <p>6 they're processing the claims and doing things like that</p> <p>7 rather than making the core strategic decisions for</p> <p>8 Aetna. So that's the argument for why there might be</p> <p>9 reduced efficiency.</p> <p>10 And that you're right, on the PBM side of the</p> <p>11 market, you know, at least for the administrative side</p> <p>12 of PBM services, Aetna will no longer be in the market</p> <p>13 because it will now have a more permanent relationship</p> <p>14 with, CVS and therefore it's excluded from the market.</p> <p>15 Or maybe another way to think about this is</p> <p>16 that, you know, Aetna might never enter the PBM market</p> <p>17 for either core services or administrative services</p> <p>18 because now it has both those capacities in house. And</p> <p>19 since it won't enter the PBM market, it's reducing the</p> <p>20 size of the overall market and that might have</p> <p>21 anticompetitive device effects.</p> <p>22 COMMISSIONER JONES: I think I understand. In</p> <p>23 part though, the weight of each argument is somehow</p> <p>24 contingent on the degree to which Aetna is internally</p> <p>25 providing its on PBM services versus the degree to which</p> <p>Page 169</p>

<p>1 it's relying on CVS Caremark for PBM services. 2 MR. SOOD: Yes, you're absolutely right. 3 COMMISSIONER JONES: Okay. 4 At some juncture we'll give Aetna and CVS a 5 chance to respond to that, but I just noted that there 6 seemed to be an inconsistency there, but I understand 7 now why there might not be. 8 Let me see if Ms. Rocco has any questions. 9 DEPUTY COMMISSIONER ROCCO: This question is 10 for whichever witness, or if more of you have a thought 11 on this. 12 In California the five largest health insurers 13 are not the same five companies that are our nation's 14 five largest health insurers. And as we've been talking 15 about today, whether we're talking about United and 16 Optum, whether we're talking about what Anthem is in the 17 process of doing, what Aetna would be doing with this 18 merger, what Cigna is trying to do with Express Scripts, 19 you may end up with the consolidation of the PBM 20 services with health insurers with most of the nation's 21 largest five health insurers -- which, as I'm saying, 22 are not the same five that are the biggest in 23 California. 24 So for those in California that would not be 25 merged with a PBM, how would we expect this merger or</p> <p>Page 170</p>	<p>1 deployed vis a vis the pharmacies or rival insurers to 2 disadvantage them, and it's hard to cover all these 3 things in a consent decree. 4 That's why the current assistant attorney 5 general, one of his first speeches, was he doesn't 6 believe in those decrees because they have proven to be 7 evaded or ineffective, hard to predict the future. 8 So there's a real slippery slope here about 9 what kind of remedy is out there to get the promise of 10 good behavior and ultimately have somebody to monitor it 11 and enforce it. 12 The entities best positioned to do that, I 13 think, are the insurance commissions that are in 14 day-to-day regulation. But again, those are, those 15 behavioral decrees are hard to enforce and hard to 16 arrive at. 17 MS. MOSS: This is Diana Moss. If I may just 18 chime in on the first part of your question, which is 19 really a good one. And it harks back to a comment that 20 I made in my presentation, that if we do migrate, have 21 this sort of sea shift change in the industry from 22 unintegrated PBMs, pharmacies, and health insurers to 23 integrated PBM, insurers, and that is a massive, massive 24 change in the landscape. 25 And what comes with it are some pretty</p> <p>Page 172</p>
<p>1 the Cigna-Express Scripts proposed merger to impact 2 those companies in terms of drug costs, in terms of 3 contracting with PBMs, in terms of drug formulary 4 design. What are some of the impacts specifically, and 5 then if the merger does occur, are there any things that 6 we can do with the health insurers we regulate in terms 7 of agreements we might seek from them to mitigate those 8 impacts on the other health insurers in the market? 9 MR. GREANEY: That's a question that I thought 10 would be asked. There's a real question about what you 11 do about all this if you decide, if the Justice 12 Department decides there is a problem here. 13 One is they can litigate and try to block the 14 merger, get a full-stop injunction. But the other, 15 historically there have been ten or more vertical 16 mergers examined by the courts very succinctly because a 17 consent decree was the only thing in front of them, and 18 those consent decrees typically included promises to 19 change their conduct, to deal fairly with their upstream 20 or downstream rivals, and that's, you know, that's 21 attractive to courts because they, you know, they like 22 to settle cases. 23 On the other hand, those conduct behavioral 24 decrees are pretty problematic. Because I think you 25 heard a litany of potential tactics that might be</p> <p>Page 171</p>	<p>1 troubling, concerning things, not only for competition 2 but for consumers. 3 And one is, of course, that if you have a 4 bunch of vertically integrated PBM insurers lined up in 5 the industry, you can pretty much forget about new entry 6 at any single level, whether it be at the PBM level, say 7 a smaller innovate PBM or a retail pharmacy or mail 8 order pharmacy, standalone pharmacies, or a new health 9 insurance model, you can forget about that. 10 Because the only way those firms are going to 11 be able to compete is if they themselves enter at two 12 levels. This is sort of an old antitrust concern that 13 surrounds vertical consolidation and it's called 14 two-level entry. Meaning that it's now, you know, you 15 just raised the bar on everybody trying to get in to the 16 industry. Now it's going to be harder to get in at one 17 level and it's going to be a forced march towards 18 two-level entry. 19 And that immediately peels off a whole bunch 20 of possible entrants who could have been innovative, 21 disruptive, brought competitive discipline to the 22 market. I think it's a huge risk, an enormous risk in 23 the bigger landscape, particularly as we look at 24 CVS-Aetna, also Express Scripts-Cigna against, you know, 25 United-Optum already in the market as an integrated</p> <p>Page 173</p>

<p>1 entity.</p> <p>2 So I think it raises very serious concerns.</p> <p>3 COMMISSIONER JONES: So another question that</p> <p>4 I have is, and this is to any of the witnesses, each of</p> <p>5 you has identified a number of problems associated with</p> <p>6 the vertical integration of CVS and Aetna and some of</p> <p>7 those problems are specific to the kind of behavior that</p> <p>8 you anticipate might occur as a result of that merger.</p> <p>9 We have an example in United and Optum of a</p> <p>10 vertically integrated health insurer and health plan</p> <p>11 with a PBM, and I'm just curious what does the evidence</p> <p>12 or data show with regard to how they are been behaving</p> <p>13 in the market, if there such evidence or data, if</p> <p>14 anybody knows.</p> <p>15 MS. MOSS: This is Diana Moss. I'll just</p> <p>16 chime in that I think, from my understanding, is that</p> <p>17 United Healthcare and Optum have kept the doors open.</p> <p>18 They will deal with all comers. They have not gone to a</p> <p>19 closed system where they only serve, you know, to a</p> <p>20 exclusive exclusivity model.</p> <p>21 But at the same time Optum is small. It's not</p> <p>22 an enormous dominant PBM as we see with Express Scripts</p> <p>23 and CVS. That's a very very different fact pattern than</p> <p>24 what we see with these proposed mergers that are on the</p> <p>25 table.</p> <p>Page 174</p>	<p>1 know the incentives are there, but to find actual</p> <p>2 behavior that hurts consumers or -- it's very difficult</p> <p>3 to figure that out because these contracts are shrouded</p> <p>4 in, kind of, they are not very transparent. It's very</p> <p>5 difficult to though what's going on.</p> <p>6 COMMISSIONER JONES: That's a good point. I</p> <p>7 mean as a state regulator, we have very little line of</p> <p>8 sight into the contracts or the behavior of PBMs, and no</p> <p>9 direct regulatory authority over them. So the point you</p> <p>10 make is, I think, a good one from the state regulatory</p> <p>11 standpoint.</p> <p>12 I think one of you made a point earlier that</p> <p>13 once the merger occurs, the ability to utilize antitrust</p> <p>14 law to go after some of the behavior that each of you</p> <p>15 have described, is very limited. So that may be even</p> <p>16 more acute with regard to PBMs since state regulatory</p> <p>17 apparatuses have little, if any, oversight with regard</p> <p>18 to their behavior.</p> <p>19 Any other questions you have? Okay.</p> <p>20 I want to thank each of the panelists very,</p> <p>21 very much for your taking the time to travel here to</p> <p>22 testify. I want to thank Ms. Moss for appearing</p> <p>23 telephonically. I know she would have been here if she</p> <p>24 could have. And we have your oral testimony as well as</p> <p>25 any written materials that have you provided that will</p> <p>Page 176</p>
<p>1 So it's also true that they are the only</p> <p>2 vertically integrated PBM insurer. If others pop up in</p> <p>3 the industry landscape, that will change, potentially</p> <p>4 change United-Optum's incentives themselves, right?</p> <p>5 It's all about the competitive landscape around you and</p> <p>6 how you fit into that, that governs competitive</p> <p>7 strategy, decisions to keep your system open and deal</p> <p>8 with all comers or whether to engage in sort of an</p> <p>9 exclusionary or, exclusionary conduct or to go to an</p> <p>10 exclusive model.</p> <p>11 So I think that is a really really good</p> <p>12 question, but I think, you know, all bets are off. If</p> <p>13 these deals go through and we see this massive sea</p> <p>14 shift, we're going to see some very different incentives</p> <p>15 for how these vertically integrated entities behave.</p> <p>16 COMMISSIONER JONES: Anyone else want to add</p> <p>17 anything?</p> <p>18 MR. SOOD: I think the other thing is that</p> <p>19 it's just very difficult to monitor the behavior of a</p> <p>20 PBM and how well it is serving the health plan. These</p> <p>21 contracts are fairly complicated. You know, there could</p> <p>22 be can kind of complex effects of the decision that PBM</p> <p>23 makes on healthcare costs in the future. You might not</p> <p>24 see them right away.</p> <p>25 So I think in general it's very difficult, we</p> <p>Page 175</p>	<p>1 be made a part of the record. And we do really</p> <p>2 appreciate your participation in today's hearing.</p> <p>3 Thank you very, very much. Thank you.</p> <p>4 MS. MOSS: Thank you.</p> <p>5 COMMISSIONER JONES: So now we'll move to our</p> <p>6 next panel, which is a Provider panel. And I would like</p> <p>7 to welcome those witnesses.</p> <p>8 So welcome. Maybe I could just ask if each of</p> <p>9 you could introduce yourselves in turn, and then I'm not</p> <p>10 sure which order you would like to go in, but it's up to</p> <p>11 you as to which order you'd like to go in.</p> <p>12 Welcome.</p> <p>13 MR. DO: Good afternoon, Commissioner. My</p> <p>14 name is Long Do, and I'm legal counsel with the</p> <p>15 California Medical Association.</p> <p>16 MS. MCANENY: I'm Barbara McAneny. I'm</p> <p>17 president of the American Medical Association.</p> <p>18 COMMISSIONER JONES: We're delighted to have</p> <p>19 both of you here today, and we want to thank Ms. McAneny</p> <p>20 for having traveled a great distance to be with us, and</p> <p>21 it's a real privilege to have you here, too.</p> <p>22 Our agenda has you starting. Would you like</p> <p>23 to start?</p> <p>24 MS. MCANENY: I would be honored to. Thank</p> <p>25 you.</p> <p>Page 177</p>

<p>1 COMMISSIONER JONES: Great. Welcome.</p> <p>2 MS. MCANENY: And I didn't actually travel</p> <p>3 that far. I live in New Mexico.</p> <p>4 COMMISSIONER JONES: Parts of New Mexico are</p> <p>5 really hard to get to. I've been to Chaco Canyon, and</p> <p>6 that was a long drive from Albuquerque.</p> <p>7 MS. MCANENY: That's one of the hardest.</p> <p>8 COMMISSIONER JONES: But one of the most</p> <p>9 beautiful and inspiring places ever to visit.</p> <p>10 MS. MCANENY: I have a clinic in the Gallup</p> <p>11 area, so, yes.</p> <p>12 COMMISSIONER JONES: Well, kudos to New</p> <p>13 Mexico. Thanks.</p> <p>14 MS. MCANENY: Thank you.</p> <p>15 On behalf of the American Medical Association,</p> <p>16 the AMA, and its student and physician members, I really</p> <p>17 appreciate the opportunity to provide our views</p> <p>18 regarding the proposed CVS-Aetna merger and it's</p> <p>19 implications for California patients.</p> <p>20 We commend the California Department of</p> <p>21 Insurance and California Commissioner David Jones for</p> <p>22 holding this hearing. You have shown great leadership,</p> <p>23 and I know the rest of the country is listening to you</p> <p>24 today as you examine this massive healthcare merger.</p> <p>25 My comments will express my opinions as a</p> <p>Page 178</p>	<p>1 pharmacies are collected by the three largest firms</p> <p>2 owned by CVS Health, Express Scripts, and Walgreens</p> <p>3 Boots Alliance.</p> <p>4 CVS Specialty Pharmacy itself is the biggest</p> <p>5 player in the specialty business with a 25 percent</p> <p>6 market share measured by specialty pharmacy revenues,</p> <p>7 and CVS' specialty pharmacy market share is growing as</p> <p>8 described in CVS Health 2017 Annual Report where CVS</p> <p>9 specifically states, quote, "We remain the largest</p> <p>10 specialty pharmacy by a considerable margin, resulting</p> <p>11 in greater scale and stronger purchasing economics.</p> <p>12 Looking at 2018, we expect to continue</p> <p>13 outpacing the marketplace by adding another \$4 billion</p> <p>14 in specialty revenue." End quote.</p> <p>15 Specialty pharmacy is driving the pharmacy</p> <p>16 industry's revenue growth. According to Pembroke</p> <p>17 Consulting, quote, "The growth of specialty drugs is</p> <p>18 reshaping the pharmacy and the pharmacy benefit manager</p> <p>19 industries. The specialty pharmacy market represents a</p> <p>20 growing proportion of drug costs."</p> <p>21 The proposed CVS-Aetna merger has worrisome</p> <p>22 ramifications in the specialty market where CVS is the</p> <p>23 largest player. Already CVS' status is one of the two</p> <p>24 largest PBMs in a concentrated market, has allowed it to</p> <p>25 effectively force many patients and third-party payers</p> <p>Page 180</p>
<p>1 physician, as an oncologist who has treated some of the</p> <p>2 most vulnerable patients for over 30 years, and I will</p> <p>3 end by briefly stating the AMA's position on the merger.</p> <p>4 I have practiced oncology in New Mexico for 30</p> <p>5 years, and I currently am the president of the American</p> <p>6 Medical Association, and I believe that if approved, the</p> <p>7 CVS-Aetna merger could pose a very serious threat to the</p> <p>8 quality of care and safety of cancer patients in my</p> <p>9 practice and across the country because of the merger's</p> <p>10 potential impact on the specialty pharmacy market.</p> <p>11 Oncologists rely heavily on specialty drugs to</p> <p>12 treat their patients. Those drugs are invaluable in the</p> <p>13 fight against cancer and can literally make the</p> <p>14 difference between life and death.</p> <p>15 But oncology is not the only physician</p> <p>16 specialty that depends on specialty drugs.</p> <p>17 Rheumatologists, ophthalmologists, gastroenterologists,</p> <p>18 neurologists and others do as well.</p> <p>19 Specialty drugs play a critical role in caring</p> <p>20 for patients, especially patients with complex diseases</p> <p>21 like cancer, cystic fibrosis, autoimmune disease, HIV</p> <p>22 Aids and many others.</p> <p>23 Data indicates that the specialty pharmacies</p> <p>24 operate in a very concentrated market. Nearly</p> <p>25 60 percent of all prescription revenues from specialty</p> <p>Page 179</p>	<p>1 to utilize CVS as their specialty pharmacy. If</p> <p>2 approved, the merged CVS-Aetna would permanently extend</p> <p>3 this practice to Aetna covered patients.</p> <p>4 And there's tremendous incentive for CVS to do</p> <p>5 this. Not only does the specialty pharmacy market</p> <p>6 represent an growing proportion of drug costs, many</p> <p>7 specialty pharmacy drugs are very expensive, and as a</p> <p>8 PBM, CVS Caremark makes a profit on the percentage of</p> <p>9 drug costs. CVS can maximize these profits by using</p> <p>10 financial incentives to force patients, as a practical</p> <p>11 matter, to utilize CVS' specialty pharmacy for the</p> <p>12 dispensing or administration of specialty drugs rather</p> <p>13 than a treatment setting such as a hospital or a</p> <p>14 physician office.</p> <p>15 For example, CVS-Aetna could set Aetna</p> <p>16 enrollees' copays for chemotherapy drugs at negligible</p> <p>17 levels when obtaining those drugs through the CVS</p> <p>18 specialty pharmacy, and impose a much higher level, like</p> <p>19 the 20 percent copay, on enrollees if they obtain the</p> <p>20 same drugs in treatment settings, such as physician</p> <p>21 practices or hospitals.</p> <p>22 This is bad because it fragments care and</p> <p>23 removes the oversight of chemotherapy from the treating</p> <p>24 oncologist. Given the high cost of many specialty</p> <p>25 drugs, most Aetna patients will have no choice but to</p> <p>Page 181</p>

<p>1 utilize CVS' specialty pharmacy.</p> <p>2 The potential for abuse is largest in the</p> <p>3 commercial market. However, Aetna's Medicare Advantage</p> <p>4 enrollees, for whom Aetna is responsible for drug</p> <p>5 utilization regardless of the site of administration,</p> <p>6 could be affected as well.</p> <p>7 While the CVS specialty pharmacy might for</p> <p>8 some patients be a lower cost setting for obtaining or</p> <p>9 administering drugs, compelling patients to utilize CVS</p> <p>10 specialty pharmacy as opposed to a hospital or physician</p> <p>11 practice, raises quality of care and patient safety</p> <p>12 concerns.</p> <p>13 Patients' use of some specialty drugs requires</p> <p>14 medical monitoring. Take oral chemotherapy drugs for</p> <p>15 example, despite being in pill form, oral chemotherapy</p> <p>16 drugs are powerful and potentially dangerous.</p> <p>17 Consequently, cancer patients taking oral chemotherapy</p> <p>18 have to be monitored by a physician trained in oncology</p> <p>19 to ensure that these drugs are properly dosed, and</p> <p>20 accordingly, there is a local market for dispensing and</p> <p>21 administration of oncology drugs. Compelling the</p> <p>22 patients to utilize CVS' specialty pharmacy can make it</p> <p>23 difficult for an oncologist like me to perform this sort</p> <p>24 of monitoring.</p> <p>25 Cutting out clinical settings such as a</p> <p>Page 182</p>	<p>1 Oral chemotherapy is just the beginning.</p> <p>2 CVS-Aetna can financially compare Aetna patients needing</p> <p>3 IV chemotherapy to have those drugs delivered at the</p> <p>4 patient's home or at the CVS infusion centers where CVS</p> <p>5 nurses would administer the chemotherapy.</p> <p>6 This practice raises even greater quality of</p> <p>7 care and patient safety concerns than those I have just</p> <p>8 mentioned regarding oral chemotherapy. Patients can</p> <p>9 have very serious reactions to IV cancer drugs, and in</p> <p>10 such cases not having a trained oncologist on site to</p> <p>11 manage the reactions and supervise patients is a recipe</p> <p>12 for disaster.</p> <p>13 What guarantees will there be that the person</p> <p>14 CVS sends to perform administration will be sufficiently</p> <p>15 trained to handle these life threatening contingencies</p> <p>16 or even have the equipment or the drugs necessary?</p> <p>17 When quality of care issues arise between me</p> <p>18 and a PBM concerning one of my patients, I can currently</p> <p>19 take the problem to the insurer. Today Aetna is free to</p> <p>20 weigh my patient's quality demands against the financial</p> <p>21 concerns. This weighing also occurs between Aetna and a</p> <p>22 CVS at their contract renewal time.</p> <p>23 However, once Aetna has a permanent ownership</p> <p>24 in CVS, Aetna will have a financial interest in CVS'</p> <p>25 specialty pharmacy continuing to gain market share and</p> <p>Page 184</p>
<p>1 physician practice or hospital from the dispensing or</p> <p>2 administration of chemotherapy drugs raises other</p> <p>3 patient safety concerns. For example, with any</p> <p>4 chemotherapy drug, patient adherence to the medication</p> <p>5 regimen is essential to maximizing the chances of the</p> <p>6 drug's effectiveness, and consequently patients'</p> <p>7 survival.</p> <p>8 Removing clinical settings from the equation</p> <p>9 compromises an oncologist's ability not only to ensure</p> <p>10 adherence, but also to follow where the patient is in</p> <p>11 his or her chemotherapy cycle.</p> <p>12 It's important to understand how this works in</p> <p>13 the real world. When chemotherapy medicines are not</p> <p>14 dispensed or administered in the physician practice, all</p> <p>15 too often the oncologist is not provided with key</p> <p>16 information such as when, or if, the medication has been</p> <p>17 delivered, when, or if, the patient has started taking</p> <p>18 the medication, and when, or if, refills have been</p> <p>19 requested, and if the refill request has been made that</p> <p>20 incorporate the oncologist change in the dosage, dosage</p> <p>21 intervals, or other instructions.</p> <p>22 This lack of information greatly hinders my</p> <p>23 ability to protect my patients from dangerous or</p> <p>24 unwanted side effects, adverse patient reactions, or</p> <p>25 toxic drug levels.</p> <p>Page 183</p>	<p>1 be less responsive to my patient demands.</p> <p>2 Let me emphasize that the concerns I have</p> <p>3 voiced today are not unique to me, nor is it mere</p> <p>4 speculation. Indeed, the likely harmful effect that a</p> <p>5 combined CVS-Aetna may have on the quality of patient</p> <p>6 care is described in an online article appearing in The</p> <p>7 Lancet, one of the world's most preeminent medical</p> <p>8 journals.</p> <p>9 In The Lancet article entitled, quote, "Major</p> <p>10 Healthcare Companies Merge in the USA," the author</p> <p>11 writes, quote, "A substantial share of CVS Health's</p> <p>12 pharmacy revenue are derived from specialty pharmacies</p> <p>13 which distribute expensive drugs including chemotherapy</p> <p>14 agents. The company might press patients to obtain</p> <p>15 drugs that would be better provided through a</p> <p>16 physician's office internally."</p> <p>17 "These are very expensive drugs and they can</p> <p>18 hurt you if they aren't managed closely," explained Ray</p> <p>19 Dean Page, the incoming chair of the Clinical Practice</p> <p>20 Committee of the American Society of Clinical Oncology.</p> <p>21 Finally, I ask you to not forget that CVS'</p> <p>22 tying of the purchase of its specialty drugs to</p> <p>23 reasonable access to health insurance is among the</p> <p>24 allegations against it in a class action suit filed in a</p> <p>25 California federal court entitled John Doe 1 et al.</p> <p>Page 185</p>

<p>1 versus CVS Health Corporation filed February 16th, 2018.</p> <p>2 This suit claims that many enrollees in health</p> <p>3 plans where CVS controls and administers the pharmacy</p> <p>4 benefits are told they have to obtain their HIV Aids</p> <p>5 medications from CVS' California specialty pharmacy, a</p> <p>6 wholly owned subsidiary of CVS.</p> <p>7 It is asserted in this lawsuit that patients</p> <p>8 allegedly are, quote, "Told they must either pay more</p> <p>9 out of pocket or pay full price with no insurance</p> <p>10 benefits, whatever, thousands of dollars or more each</p> <p>11 month to purchase their medications at an in-network</p> <p>12 community pharmacy where they are receive counseling</p> <p>13 from a pharmacist and other services that they made need</p> <p>14 to stay alive."</p> <p>15 While these claims are not yet proven, similar</p> <p>16 allegations are being made in a Florida lawsuit, Sentry</p> <p>17 Data Systems versus CVS Health. In Sentry, the</p> <p>18 Plaintiff alleges that CVS forces patients and</p> <p>19 third-party payers to utilize CVS as their specialty</p> <p>20 pharmacy.</p> <p>21 In sum, CVS' acquisition of Aetna exacerbates</p> <p>22 the concerns I've described personally as an oncologist,</p> <p>23 as well as the allegations in these lawsuits. So thank</p> <p>24 you again for allowing me to present my opinions as a</p> <p>25 practicing oncologist strongly opposed to this</p> <p>Page 186</p>	<p>1 Let's hear now from Mr. Long Do from the</p> <p>2 California Medical Association.</p> <p>3 MR. DO: Thank you, Commissioner.</p> <p>4 I will be making statements on behalf of the</p> <p>5 California Medical Association. CMA thanks you for the</p> <p>6 opportunity to present comments on the proposed merger</p> <p>7 between CVS Health and Aetna.</p> <p>8 The California Medical Association is one of</p> <p>9 the nation's largest and oldest state physician</p> <p>10 organizations currently comprised of about 45,000</p> <p>11 members. Our mission is to promote the science and art</p> <p>12 of medicine, protection of public health, and the</p> <p>13 betterment of the medical profession. As a pillar of</p> <p>14 California's healthcare provider community, CMA has</p> <p>15 serious concerns about the negative impact of the</p> <p>16 proposed merger of Aetna in to CVS Health.</p> <p>17 Several prominent organizations have raised</p> <p>18 red flags over the anticompetitive effects and harm to</p> <p>19 consumers that could result from the proposed merger.</p> <p>20 The AMA and the American Antitrust Institute are opposed</p> <p>21 to it. CMA finds many of the concerns that have been</p> <p>22 raised by these organizations to be both on point and</p> <p>23 deeply troubling. We find strong merit in the analysis</p> <p>24 that a combined CVS-Aetna venture has great potential to</p> <p>25 raise barriers to market entry in the PBM market.</p> <p>Page 188</p>
<p>1 healthcare merger that would impede my caring for cancer</p> <p>2 patients.</p> <p>3 Also, as president of the AMA, I can report</p> <p>4 that the AMA has been painstakingly analyzing this</p> <p>5 merger, an analysis that started almost as soon as the</p> <p>6 merger was officially announced. The AMA sought the</p> <p>7 view of prominent health economists, health policy and</p> <p>8 antitrust experts, some of whom you heard from today.</p> <p>9 After very carefully considering this merger</p> <p>10 over the past months, the AMA has come to the conclusion</p> <p>11 that this merger would substantially lessen competition</p> <p>12 in many healthcare markets to the detriment of patients.</p> <p>13 What we heard today corroborates this conclusion.</p> <p>14 From my vantage point as a physician, the</p> <p>15 reduction in competition threatens to have real life</p> <p>16 consequences for patients struggling for survival.</p> <p>17 Accordingly, based on the mutually confirming analysis</p> <p>18 and conclusions presented by the nationally recognized</p> <p>19 experts heard from today, and other experts, as well as</p> <p>20 extensive research, the AMA is now convinced that the</p> <p>21 proposed CVS-Aetna merger should be blocked.</p> <p>22 Thank you.</p> <p>23 COMMISSIONER JONES: Thank you, very much</p> <p>24 Dr. McAneny. Thank you, again, for your testimony and</p> <p>25 for joining us here.</p> <p>Page 187</p>	<p>1 Additionally, CVS' acquisition and control of</p> <p>2 the nation's third largest healthcare insurer has real</p> <p>3 potential for abuses in price manipulation, unlawful</p> <p>4 tying arrangements, unequal treatment of other</p> <p>5 competitors, and other anticompetitive behavior.</p> <p>6 Ultimately, California consumers may have to</p> <p>7 pay more for healthcare in a more concentrated</p> <p>8 healthcare market while having less access to care.</p> <p>9 CMA is continuing to evaluate recent expert</p> <p>10 reports and comments, and we intend to express further</p> <p>11 views on the proposed merger in our written comments to</p> <p>12 the Department, including whether CMA opposes it.</p> <p>13 Now I would like to focus the Department's</p> <p>14 attention on a different sort of problem with the</p> <p>15 proposed merger, one that has not been discussed today.</p> <p>16 Aetna and CVS claim their combined businesses</p> <p>17 would create an alternative front door to healthcare</p> <p>18 where patients can go to retail pharmacies with walk-in</p> <p>19 clinics for primary and preventative care.</p> <p>20 Such a proposed business could run afoul of</p> <p>21 California's bar on the corporate practice of medicine,</p> <p>22 which for more than 100 years has ensured that</p> <p>23 Californians have access to professional care by</p> <p>24 physicians who have an undivided loyalty to their</p> <p>25 patients and who are bound by legal and ethical</p> <p>Page 189</p>



<p>1 obligations to put the health interests of their 2 patients first.</p> <p>3 CVS currently owns 10,000 retail pharmacy 4 chain stores and another 1100 MinuteClinics within these 5 stores. Aetna and CVS claim that they could keep 6 healthcare costs down under their proposed merger by 7 routing patients to CVS stores and the MinuteClinics, 8 away from hospital emergency departments or urgent care 9 centers that are staffed by physicians.</p> <p>10 CVS stores and clinics, however, are staffed 11 by nonphysicians, pharmacists, nurse practitioners, and 12 physician assistants. CVS claims these nonphysicians 13 can provide routine and diagnostic care.</p> <p>14 California's corporate bar prohibits lay 15 individuals, organizations, and corporations from 16 practicing medicine. It also prohibits direct and 17 indirect controls over the practice of medicine. Thus, 18 lay persons and entities cannot hire or employ 19 physicians to provide medical care or otherwise 20 interfere with or control a physician's professional 21 judgment.</p> <p>22 The underlying rationale of the corporate bar 23 can be found in our state decision as early as 1938, 24 when the California Supreme Court explained that "The 25 bar guards against the evils of divided loyalty and</p> <p>Page 190</p>	<p>1 here, and here is the quote: "We cannot imagine any 2 consideration of public policy that would cause us to 3 impute to the legislator the intent to, on the one hand, 4 ban corporate ownership of medical practices, and on the 5 other, permit such ownership through mere straw 6 MinuteClinic acting on behalf of the corporation."</p> <p>7 CMA thanks the Commissioner again for focusing 8 attention on this historic merger and for considering 9 our comments.</p> <p>10 COMMISSIONER JONES: Thank you. Do you have a 11 citation to that case?</p> <p>12 MR. DO: I do. We will provide it in our 13 written comments, but the latter case is San Joaquin 14 Community Hospital versus San Joaquin Valley Medical 15 Group. It comes out of the 5th District Court of 16 Appeal. The Westlaw citation is 2004 Westlaw 139855.</p> <p>17 COMMISSIONER JONES: Great, thank you.</p> <p>18 Let me see if Ms. Rocco has any questions for 19 this manufacturer.</p> <p>20 I don't. Thank you very, very much. I really 21 appreciate the opportunity to get the physician view 22 with regard to the impacts of the proposed merger, and I 23 appreciate both of you taking the time to testify. We 24 will give, obviously, very strong and serious 25 consideration to your testimony. So thank you. Thank</p> <p>Page 192</p>
<p>1 impaired confidence in the practice of medicine."</p> <p>2 The medical board of California has identified 3 numerous aspects of the practice of medicine that would 4 be violated when undertaken or influenced by non 5 physicians. Some of these include determining what 6 diagnostic tests are highly appropriate for a particular 7 condition, determining the need for referrals to or 8 consultation with another physician or specialist, lay 9 ownership over a patient's medical records, and 10 selection of professional physician extenders or other 11 allied health staff.</p> <p>12 CVS' MinuteClinics, to the extent they engage 13 non physicians such as nurse practitioners or 14 pharmacists to practice medicine, sometimes perhaps 15 beyond the scope of their professional license, poses 16 substantial concerns under the corporate bar. The 17 increased reliance on these practices as a claimed 18 efficiency of the proposed CVS-Aetna merger, should 19 raise serious red flags.</p> <p>20 Finally, it is not enough that the 21 MinuteClinics in California may be individually 22 physician-owned, as has been suggested by CVS during 23 public testimony before the Department of Managed 24 Healthcare. One California court's view on the use of 25 such captive professional corporations is worth quoting</p> <p>Page 191</p>	<p>1 you both.</p> <p>2 So we have a consumer panel, but maybe we'll 3 take -- you're okay?</p> <p>4 COURT REPORTER: It hasn't been two hours yet.</p> <p>5 COMMISSIONER JONES: Well, you haven't heard 6 the consumers yet, either.</p> <p>7 COURT REPORTER: That's true.</p> <p>8 COMMISSIONER JONES: Okay, why don't we go to 9 the consumer panel.</p> <p>10 We welcome the three witnesses on this panel. 11 So welcome. And perhaps you might introduce yourselves 12 in turn, and then I think in order of the agenda it's 13 Dena Mendleson with Consumers Union, Yasmin Peled with 14 Health Access, and then Ben Powell with Consumer 15 Watchdog.</p> <p>16 But please introduce yourselves, and if you 17 want to go in a different order, that's fine, too.</p> <p>18 MS. MENDLESON: Commissioner, thank you for 19 the opportunity to be here today and to discuss the 20 proposed merger of CVS and Aetna.</p> <p>21 My name is Dena Mendleson. I'm a senior staff 22 attorney at Consumer Union, the advocacy division of 23 Consumer Reports.</p> <p>24 Our mission is to work for a fair, just, and 25 safe marketplace for all consumers, and to empower</p> <p>Page 193</p>

<p>1 consumers to make educated decisions that are right for 2 themselves and for their families.</p> <p>3 For consumers to have a meaningful choice, 4 there must be effective competition. One piece of 5 advice that we give again and again, is to shop around 6 for health insurance, for the lowest cost prescription 7 drug, and for the best value provider.</p> <p>8 When consumers can have options, businesses 9 are motivated to provide more affordable, better 10 quality, and new thinking in response to consumers' 11 wants and needs. Unchecked consolidation could 12 eliminate that.</p> <p>13 Because of the complexities of this 14 marketplace in particular, it is important that there be 15 competitive market forces at work to discipline these 16 profit maximizing incentives to make sure the 17 marketplace works effectively for consumers.</p> <p>18 A merger between CVS and Aetna would have a 19 major impact on nearly every segment of the healthcare 20 system. Combining these two giants would create an even 21 bigger giant with a new corporate structure, straddling 22 more market sectors and creating new and potentially far 23 reaching profit maximizing incentives.</p> <p>24 To the extent those new incentives drive the 25 combined company to integrate its resources in new ways</p> <p>Page 194</p>	<p>1 except to CVS-Aetna. For example, CVS-Aetna might tell 2 Aetna policy holders they can only go to a MinuteClinic, 3 not to a conveniently located walk-in clinic run by 4 someone else. Or they might direct them to fill 5 prescriptions only at CVS. Or to use MinuteClinics for 6 an expanded set of medical needs instead of seeing their 7 own doctor. Or CVS Caremark might negotiate different, 8 better prescription drug deals but only for Aetna 9 insurance or only for purchasers at CVS.</p> <p>10 The black box surrounding back-end PBM rebates 11 and side agreements make this area particularly open to 12 abuse. And as you mentioned earlier today, 13 Commissioner, PBMs do not have a clear regulator, and 14 once this merger goes forward it would be difficult to 15 understand what is going on or to control it.</p> <p>16 Moreover, sometimes what we're loosely 17 describing as "efficiencies" are revealed on closer 18 inspection to involve reducing competition in ways that 19 harm consumers and harm quality. CVS and Aetna insist 20 that their goals will always be focused on putting 21 consumers at the center of care, taking a holistic 22 approach to health, and addressing the rising costs of 23 healthcare.</p> <p>24 But this is not about their current plans. 25 It's about how incentives and capabilities will be</p> <p>Page 196</p>
<p>1 to bring costs down and improve quality of services -- 2 or what we have heard referred to today as 3 efficiencies -- that could be good for consumers and 4 good for the overall economy. That is the picture CVS 5 and Aetna are painting.</p> <p>6 Some of the picture may actually prove to be 7 accurate. For example, encouraging Aetna policy holders 8 to use a CVS MinuteClinic for simple routine care 9 instead of a hospital emergency room would cut expenses 10 for Aetna. That might be passed along in lower costs or 11 improved services. Might. It's far from certain.</p> <p>12 For one thing, we would need enough 13 transparency and competition so that the one on the 14 receiving end, the consumers, not only can account for 15 that saving, but can also check that it's not coming out 16 are their pockets, and has some of the realistic ability 17 to insist on a share or go elsewhere. That seems 18 unlikely within our current healthcare system.</p> <p>19 Furthermore, efficiencies, which companies 20 proposing to merge will always claim, often ultimately 21 are shown to be unsubstantiated or exaggerated, and they 22 could be achieved without merging. Why does Aetna need 23 a merger to encourage policy holders to visit 24 MinuteClinics instead of emergency rooms? 25 Reduced competition would bring no benefit</p> <p>Page 195</p>	<p>1 altered by the new market-straddling corporate structure 2 that the merge would create and whether this would lead 3 to improved products and services, or instead to 4 restrictive competition and choice and to poorer 5 products and services. Genuine risks to competition 6 will not be fixed by pledges of good behavior.</p> <p>7 Furthermore, as we have heard today, vertical 8 mergers like the one discussed including major 9 corporations operating on multiple levels to supply a 10 marketing chain, can most certainly raise competition 11 concerns and falls squarely within established antitrust 12 laws.</p> <p>13 Furthermore, we would wager that there is also 14 a horizontal dimension to this merger investigation. 15 One of the attractions of this merger to Aetna is that 16 it would get its own in-house PBM in CVS Caremark. But 17 it doesn't need a merger to get one, that's just a 18 shortcut. If this merger is challenged and doesn't go 19 through, Aetna is in the position to create a PBM for 20 itself, and that would add some much needed competition 21 to this highly concentrated market sector. The 22 Department should also take that into prospect in its 23 consideration.</p> <p>24 At the conclusion of all the public meetings 25 and hearings to inspect the proposed merger, we are</p> <p>Page 197</p>

<p>1 counting on our regulators and the Department of Justice 2 to take whatever action is necessary to ensure that 3 consumers can benefit from a healthy dose of competition 4 in the healthcare marketplace. That could potentially 5 even require a full challenge of this merger. 6 Thank you again for the opportunity to discuss 7 this merger and its importance to consumers. We 8 appreciate your time in gathering evidence today and in 9 the opportunity to shed light on how the proposed merger 10 could effect competition in California's healthcare 11 marketplace, and ultimately how it could negatively 12 impact consumers. 13 COMMISSIONER JONES: Thank you. 14 MS. PELED: Thank you. My name is Yasmin 15 Peled on behalf of Health Access California, the 16 statewide healthcare consumer advocacy coalition. 17 We strongly request the insurance commissioner 18 to heavily scrutinize this proposed merger and to 19 evaluate whether it is actually good for patients, the 20 public interest, and our state's market competition. 21 While we recognize that you are still 22 collecting information from the companies and elsewhere, 23 we are deeply skeptical that this merger is in the 24 interest of patients and the public. I would like to 25 echo the points made by our coalition partner, Ms.</p> <p>Page 198</p>	<p>1 rates, undermining their family finances, especially 2 those who live paycheck to paycheck. Small business 3 purchasers had to pay more for health coverage with 4 negative impacts on our economy and health system. 5 We have no confidence that a consolidated 6 company would act differently, nor are we convinced that 7 the cost savings or efficiencies would be passed on to 8 consumers and other purchasers. 9 It is of great concern that neither party here 10 today can provide concrete information on how premiums 11 will actually be reduced due to the \$750 million in 12 savings as a result of this merger. Given Aetna's 13 previous practices of unreasonable rate increases, 14 consumers and the public should be assured in writing 15 that these unreasonable rate increases will cease in the 16 face of immense savings. 17 Second, in the midst of ongoing excessive rate 18 hikes, Aetna has continued to reject needed care for its 19 enrollees. The California Department of Managed 20 Healthcare's most recent medical survey shows Aetna 21 continues to have major deficiencies in its grievances 22 and appeals and utilization management processes. 23 In addition, a number of states, including 24 California, are investigating Aetna for claims that one 25 of its medical directors did not examine patients'</p> <p>Page 200</p>
<p>1 Mendleson, from Consumers Union. 2 Experience and research shows that consumers 3 do not often benefit from mergers. Rarely do these 4 mergers result in lower costs or better access to care 5 or quality of care. We are skeptical that the 6 combination of CVS and Aetna will yield the benefits 7 that the executives claim. They should be willing to 8 put three benefits in writing as conditions of the 9 merger. 10 In particular, CVS has not offered any 11 information on how it would correct Aetna's failure to 12 abide by basic consumer protections. We are deeply 13 concerned about giving more market power to a company 14 with Aetna's past practices, given its track record of 15 not abiding by basic patient protections. 16 Here are some of California's experiences with 17 Aetna: First, Aetna has repeatedly pursued unreasonable 18 rate increases, which you, Mr. Commissioner, have also 19 repeatedly deemed excessive and unreasonable, including 20 in 2014 and 2015. 21 While other companies have at times rolled 22 back or restricted rate increases deemed unreasonable by 23 state regulators, Aetna, and their egregious history of 24 imposing rate increases despite such findings, meant 25 California consumers had to pay unnecessarily high</p> <p>Page 199</p>	<p>1 medical records before deciding whether to approve or 2 deny care. We appreciate your work, Mr. Commissioner, 3 for investigating Aetna's processes on claims denials, 4 prior authorizations, and utilization reviews. 5 We question how Aetna can promise greater 6 access to care with this merger when currently the 7 company's policies revolve around keeping coverage and 8 care away from patients in order to keep their profits. 9 Aetna's most recent quarterly profits soared, and it was 10 yielded primarily from high premiums charged on 11 consumers. 12 CVS Health has testified that part of the cost 13 savings of this merger will be directed to improving 14 quality for consumers and patients, yet no specific 15 information has been provided. Before getting bigger 16 and creating new programs, it would be in the interest 17 of consumers that Aetna's failure to abide by basic 18 consumer protections is remedied, yet CVS as provided no 19 information on how it will do so. 20 Finally, we're concerned that vertical, or 21 even diagonal mergers such as this one, will ultimately 22 reduce competition not only in the healthcare market but 23 also in the pharmacy business, which will lead to prices 24 going up. The Consumer Financial Protection Bureau 25 recently released grim findings from a survey that shows</p> <p>Page 201</p>

<p>1 nearly half of Americans have a tough time paying for 2 basic needs, including healthcare. A recent UC Berkeley 3 PETRA Center report confirms that consolidation in the 4 healthcare industry leads to higher costs.</p> <p>5 By engaging in this unprecedented 6 consolidation, we are deeply concerned that the lack of 7 competition will provide little incentive for CVS-Aetna 8 to right the wrongs that have been done to consumers. 9 Your review of this merger should include not just a 10 traditional antitrust review, but a focus on Aetna's 11 past practices, whether this merger would allow bad 12 behavior to get bigger, whether the companies will 13 actually commitment to the promises being made, and 14 whether consumers will actually benefit.</p> <p>15 Thank you for your consideration.</p> <p>16 COMMISSIONER JONES: Thank you very much.</p> <p>17 Next witness.</p> <p>18 MR. CANETTI: Thank you, Commissioner, and the 19 Department for the opportunity to be heard.</p> <p>20 My name is Benjamin Powell. I'm a litigation 21 attorney with Consumer Watchdog. We're a public 22 interest organization based in Los Angeles with offices 23 in Washington DC as well.</p> <p>24 Consumer Watchdog is a nonprofit tax exempt 25 consumer research, education, litigation, and advocacy</p> <p>Page 202</p>	<p>1 Consumer Watchdog shares those concerns, but 2 today I would like to focus on concerns related to item 3 5 in the Department's notice, namely how the proposed 4 merger will impact the cost and quality of care 5 delivered to consumers.</p> <p>6 In particular, today my testimony will focus 7 on medical privacy, which has been a major concern of 8 our clients in recent years, specifically the privacy of 9 those in California who require HIV and AIDS 10 medications.</p> <p>11 In its announcement about the acquisition, CVS 12 CEO Larry J. Merlo said, "With the analytics of Aetna 13 and CVS Health's human touch, we will create a 14 healthcare platform built around individuals."</p> <p>15 However, both CVS and Aetna have demonstrated 16 multiple reasons to be extremely concerned about their 17 lack of commitment to protecting the privacy of their 18 enrollees. Their failures in the realm of consumer 19 privacy should give the Department considerable pause 20 before deciding to approve this acquisition and subject 21 Californians to the mercy of this consolidated entity.</p> <p>22 Persons with HIV are still unfortunately 23 subject to stigma, humiliation, mental anguish, 24 embarrassment and stress based on their HIV status. One 25 meta analysis of 119 studies demonstrated that perceived</p> <p>Page 204</p>
<p>1 organization. We were established in 1985, and we 2 utilize a combination of litigation, advocacy, and 3 public education to effectuate our mission.</p> <p>4 Our staff includes some of the nation's 5 foremost consumer advocates and experts on consumer 6 matters. Our legal staff advocates on behalf of 7 consumers before regulatory agencies, the legislature, 8 and the courts.</p> <p>9 Over the course of three decades, consumer 10 watchdog attorneys have represented consumers in 11 numerous class actions, civil lawsuits, and 12 administrative complaints, challenging unfair business 13 practices by insurers and large corporations.</p> <p>14 Relevant to today, a particular focus of our 15 litigation has been to challenge the illegal and unfair 16 business practices of health insurance companies, 17 healthcare providers, health maintenance organizations, 18 and property casualty insurance companies, including the 19 unlawful practices that violate consumer privacy and 20 healthcare rights.</p> <p>21 As we've heard today, I understand the 22 Department has asked for testimony on a number of 23 important topics related to the impact of the proposed 24 merger of CVS and Aetna on market consolidation, 25 healthcare costs, and provider networks.</p> <p>Page 203</p>	<p>1 interpersonal risks are associated with HIV disclosure, 2 and they outlined evidence of associations with anxiety, 3 fear, and worry. They may also run the risk of the loss 4 of housing, relationships, and employment when their HIV 5 status is revealed.</p> <p>6 Such studies and analysis demonstrate that 7 even if HIV positive individuals do not know and cannot 8 show who may have been made aware of their HIV status, 9 the risk of disclosure increases stress and anxiety and 10 results in personal harm and injury to them.</p> <p>11 Beginning with Aetna, Consumer Watchdog has 12 brought legal action against the company on multiple 13 occasions, including one case surrounding HIV/AIDS 14 privacy concerns over a mail order medication program.</p> <p>15 Around 2013, HIV and AIDS patients began to 16 complain that several health insurance companies 17 intended to make radical and dangerous changes to their 18 policies with respect to HIV and AIDS medications.</p> <p>19 One of the most critical of these changes was 20 the requirement that HIV and AIDS patients obtain their 21 medication via mail order, barring its plan members from 22 the longstanding practice of visiting a specialty retail 23 pharmacist to obtain and renew their prescriptions. 24 This constituted a threat to the health, safety, and 25 privacy of patients as well as violating both California</p> <p>Page 205</p>

<p>1 and Federal law.</p> <p>2 Consumer Watchdog, along with our colleagues</p> <p>3 at Whatley Kallas LLP, brought lawsuits against United</p> <p>4 Healthcare Insurance Company and Anthem Blue Cross of</p> <p>5 California, the nation's largest health insurers at the</p> <p>6 time, challenging their new mail order policies. Those</p> <p>7 two companies commendably agreed to resolve those cases</p> <p>8 by, one, permitting members to opt out of the mail order</p> <p>9 requirement, and, two, providing compensation to any</p> <p>10 members who had already been compelled to use that</p> <p>11 program. The cases garnered much national media</p> <p>12 attention, and it highlighted the threat to patient</p> <p>13 privacy and health synonymous with these mail order</p> <p>14 programs.</p> <p>15 Against this backdrop and despite the national</p> <p>16 attention, in November of the 2014 Aetna sent letters to</p> <p>17 its members announcing that it would be implementing a</p> <p>18 mail order requirement of its own for certain HIV and</p> <p>19 AIDS medications, raising all the exact same concerns as</p> <p>20 the previous cases.</p> <p>21 Aetna additionally made all visits to retail</p> <p>22 brick-and-mortar pharmacies out of network, subjecting</p> <p>23 plan members to potentially ruinous expenses. Aetna's</p> <p>24 new mail order program proposed to replace the expertise</p> <p>25 of pharmacists with access to an 800 number operated by</p> <p>Page 206</p>	<p>1 provision of new medication regimens to address changes</p> <p>2 in the disease. Community pharmacists, who often have</p> <p>3 greater contact with HIV and AIDS patients than</p> <p>4 physicians -- which has been brought up before -- and</p> <p>5 know their complete drug regimen, also provide essential</p> <p>6 advice and counseling that help these patients and their</p> <p>7 families navigate the challenges of living with a</p> <p>8 chronic and often debilitating condition.</p> <p>9 These HIV patients were forced to call in each</p> <p>10 month to renew their prescriptions and work their way</p> <p>11 through robo calls, messages, and call center staff,</p> <p>12 increasing stress and fatigue for patients who are</p> <p>13 literally fighting to stay alive and exacerbating their</p> <p>14 condition.</p> <p>15 If these HIV/AIDS patients did not obtain</p> <p>16 their specialty medication by mail, they were required</p> <p>17 to pay full price for their medication, easily thousands</p> <p>18 of dollars or more each month, to purchase their</p> <p>19 medications at a community pharmacy.</p> <p>20 The lawsuits against Aetna and Coventry also</p> <p>21 garnered extensive national media coverage, and after a</p> <p>22 hard fought legal battle, we settled that case with a</p> <p>23 great outcome. Aetna agreed to remove HIV and AIDS</p> <p>24 medications from the exorbitantly priced specialty drug</p> <p>25 tier, and discontinued the mandatory mail order</p> <p>Page 208</p>
<p>1 Aetna and staffed by customer service representatives</p> <p>2 rather than trained pharmacists. In 2014, Consumer</p> <p>3 Watchdog sued Aetna over this mandatory mail order</p> <p>4 program for HIV medications.</p> <p>5 In 2015, we brought a related action against</p> <p>6 Aetna's subsidiary, Coventry, in Florida. Consumer</p> <p>7 Watchdog argued, and continues to argue, that Aetna's</p> <p>8 treatment of HIV and AIDS patients was discriminatory</p> <p>9 under the Affordable Care Act, the Americans With</p> <p>10 Disabilities Act, and Civil Rights law due to a number</p> <p>11 of reasons.</p> <p>12 Due to the complex nature of HIV and AIDS drug</p> <p>13 regimens, patients rely on their community pharmacists</p> <p>14 who, working directly with them, monitor potentially</p> <p>15 life threatening adverse drug interactions and side</p> <p>16 effects.</p> <p>17 Mail order delivery of these medications,</p> <p>18 often requiring large refrigerated containers for</p> <p>19 example, is not a viable option for many patients and</p> <p>20 can raise major privacy implications, particularly for</p> <p>21 those individuals who have not revealed their HIV status</p> <p>22 with their employers, coworkers, friends, and roommates.</p> <p>23 Because there's no cure for HIV and AIDS, the</p> <p>24 virus continually mutates around medications prescribed</p> <p>25 to treat it, requiring constant monitoring and immediate</p> <p>Page 207</p>	<p>1 prescription program that it put into effect for</p> <p>2 individual plan members.</p> <p>3 Now, unfortunately, we have come to find out</p> <p>4 that even in settling that case, Aetna disregarded the</p> <p>5 privacy rights of its members in favor of presumably</p> <p>6 cutting costs. As part of that settlement, Aetna agreed</p> <p>7 to send a notice to all affected enrollees, advising</p> <p>8 them of their right to obtain HIV and AIDS medications</p> <p>9 from community pharmacies of their choice where their</p> <p>10 privacy would be protected.</p> <p>11 In July of 2017, Aetna or its vendor mailed</p> <p>12 the notice letter to approximately 12,000 individual</p> <p>13 Aetna enrollees nationwide, using an envelope with an</p> <p>14 oversized transparent window. The envelope window</p> <p>15 displayed a portion of the text of the notice letter</p> <p>16 itself, disclosing the fact that the notice letter was</p> <p>17 being sent to those members of Aetna health plans who</p> <p>18 had been prescribed HIV medications.</p> <p>19 In so doing, Aetna disclosed approximately</p> <p>20 12,000 individuals' HIV status to any person coming in</p> <p>21 to contact with that letter, including coworkers,</p> <p>22 neighbors, family members, roommates, apartment</p> <p>23 managers, and postal workers, egregiously violating</p> <p>24 their rights.</p> <p>25 Attorneys for Consumer Watchdog represent a</p> <p>Page 209</p>

<p>1 John Doe HIV patient in an action against Aetna for this 2 latest violation of patient privacy. We allege that 3 Aetna breached the settlement agreement in the prior 4 case by disclosing patients' HIV status in the new case 5 in the mailing sent out by Aetna. Rather than accepting 6 responsibility, Aetna has blamed others, including 7 lawyers for Consumer Watchdog, for its own privacy 8 breaches.</p> <p>9 While we would like to believe that if CVS is 10 permitted to acquire Aetna, it would help Aetna solve 11 these problems, we simply cannot expect CVS to acquire 12 Aetna to clean up the mess as CVS has demonstrated on 13 multiple occasions that it does not put a priority on 14 its own enrollees privacy rights.</p> <p>15 For example, Consumer Watchdog is also 16 involved in one lawsuit currently in California federal 17 court against CVS for implementing its own mail order 18 requirement for HIV and AIDS medications, very similar 19 to the programs that were implemented by United and 20 Anthem Blue Cross that I mentioned previously.</p> <p>21 CVS refuses to end that program, despite the 22 aforementioned litigation, and despite our continued 23 insistence that the program has serious and unavoidable 24 privacy consequences for its members taking HIV and AIDS 25 medications.</p> <p>Page 210</p>	<p>1 expect that allowing CVS to acquire Aetna will result in 2 any improvement whatsoever in these blatant violations 3 of patient privacy.</p> <p>4 These companies have already exhibited that at 5 current sizes, privacy considerations are simply not a 6 priority. Allowing these organizations to consolidate 7 into one larger entity would surely worsen these 8 problems, as more enrollees to manage will result in 9 decreased attention to the problems plaguing this very 10 at-risk and vulnerable segment of their customers.</p> <p>11 We urge the Department and the Commissioner to 12 require these two companies to first demonstrate that 13 they have a greater respect for privacy rights before 14 the merger is consummated. To that end, as a condition 15 of approving the merger, the Commissioner should require 16 CVS to embed an independent privacy overseer in the 17 company, reporting annually to the Commissioner and to 18 the public, on the actions taken by CVS and its newly 19 acquired subsidiary, Aetna, to ensure patient privacy 20 within the merged company. This will provide the 21 third-party accountability necessary to ensure that the 22 health and privacy rights of affected consumers are 23 protected.</p> <p>24 Thank you. I appreciate your time. 25 COMMISSIONER JONES: Thank you very much.</p> <p>Page 212</p>
<p>1 Additionally, in a case strikingly similar to 2 Aetna's egregious privacy breach, in the state of Ohio 3 CVS took almost exactly the same steps Aetna did, 4 sending a letter to approximately 6000 enrollees taking 5 HIV medications in an envelope with two glassine 6 windows, showing the CVS logo, the words "Ohio 7 Department of Health" and the designation PM6402 HIV 8 above the enrollee's name.</p> <p>9 The reference to the recipients HIV status was 10 plainly visible through the glassine window, with the 11 envelope referring in big red letters to new 12 prescription benefits, the privacy of enrollees were 13 once again blatantly violated in a very similar way.</p> <p>14 Consumer Watchdog, along with our co-counsel, 15 represent three John Doe plaintiffs in a lawsuit against 16 CVS in Ohio for that privacy breach. The John Doe 17 plaintiffs who have brought the class action anonymously 18 to protect their privacy, seek an injunction against CVS 19 barring it from using the transparent-windowed envelopes 20 in the future for any communications where HIV status is 21 referenced in any way.</p> <p>22 In sum, both Aetna and CVS have demonstrated a 23 lack of concern about the privacy of their enrollees, 24 especially with regard to their customers who take HIV 25 and AIDS medications. There is simply no reason to</p> <p>Page 211</p>	<p>1 Let me see if Ms. Rocco has any questions for 2 the witnesses.</p> <p>3 DEPUTY COMMISSIONER ROCCO: Just one.</p> <p>4 For the last witness, this situation you 5 described with CVS and the window envelopes, was that 6 prior to the Aetna situation?</p> <p>7 MR. POWELL: This was after the Aetna 8 situation.</p> <p>9 DEPUTY COMMISSIONER ROCCO: Thank you.</p> <p>10 COMMISSIONER JONES: Thank you each for your 11 testimony.</p> <p>12 Just to clarify something I said at the 13 beginning, though, I don't have direct approval over 14 this merger. The legislature has declined so far to 15 give me that approval because in California, the 16 Commissioner only has approval where one of the 17 companies being merged is an actual domiciled insurance 18 company in California, and that's not the case here.</p> <p>19 Clearly I have a keen interest in it as the 20 head of the Consumer Protection Agency, and for the 21 reasons I said at the beginning of the hearing, we are 22 holding this hearing to gather as much information and 23 evidence as we can, and I can certainly reach a 24 conclusion based on that information as to whether I 25 believe the merger is anticompetitive or not, but I</p> <p>Page 213</p>

<p>1 don't have direct approval authority for the merger.</p> <p>2 So I appreciate suggestions about the</p> <p>3 conditions that I might impose, but I want to make sure</p> <p>4 that people's expectations are calibrated accordingly.</p> <p>5 I don't have that authority.</p> <p>6 But thank you very, very much. I really</p> <p>7 appreciate your testimony and your taking the time to</p> <p>8 participate in the hearing today, each and every one of</p> <p>9 you.</p> <p>10 So with that, my able senior counsel's</p> <p>11 indicating a timeout, and we may just do that. Or we</p> <p>12 may see if there are any other members of the public who</p> <p>13 wish to comment at this point.</p> <p>14 There are. Okay. So do you need a little</p> <p>15 break?</p> <p>16 COURT REPORTER: We can finish these two up as</p> <p>17 long as they will breathe as they speak.</p> <p>18 COMMISSIONER JONES: With that admonition, why</p> <p>19 don't we see if there are any members of the public who</p> <p>20 would like to comment. Did we have a sign-in sheet for</p> <p>21 that purpose somewhere?</p> <p>22 Okay. So a number of people filled out this</p> <p>23 form, and some of them indicated they would like to make</p> <p>24 a public comment.</p> <p>25 Is Tanya Stevenson here from Breathe</p> <p>Page 214</p>	<p>1 founded here in San Francisco about 100 years ago.</p> <p>2 Breathe California as a whole is a statewide</p> <p>3 network of five non profit organizations dedicated to</p> <p>4 protecting lung health. We were thrilled to learn that</p> <p>5 CVS Health made the decision to voluntarily stop selling</p> <p>6 tobacco products in its stores in 2014.</p> <p>7 Breathe California has worked for decades to</p> <p>8 prevent teens and preteens from starting to use tobacco</p> <p>9 products and to help smokers quit smoking. We also</p> <p>10 provide services to many adults suffering from emphysema</p> <p>11 and COPD, which are usually the result of years of</p> <p>12 smoking. So removing tobacco products from its stores</p> <p>13 is extremely significant.</p> <p>14 Ninety-five million fewer packs of cigarettes</p> <p>15 were sold just eight months after the end of tobacco</p> <p>16 sales. CVS no longer believed it was okay for someone</p> <p>17 to buy tobacco in the front of their stores, and then</p> <p>18 walk to the back of the store to pick up the medication</p> <p>19 they needed in the pharmacy to help fight their</p> <p>20 tobacco-related disease.</p> <p>21 And they were just in time. Because just what</p> <p>22 when we thought smoking was no longer the epidemic that</p> <p>23 it once had been, vaping and juuling have hit our middle</p> <p>24 schools and high schools like a brick. Teachers,</p> <p>25 parents, and administrators are unable to identify the</p> <p>Page 216</p>
<p>1 California? Welcome. Come on up.</p> <p>2 And then Julian, is it Canetu?</p> <p>3 MR. CANETTI: Canetti.</p> <p>4 COMMISSIONER JONES: Sorry. Welcome.</p> <p>5 And let's see, who else? Those are the</p> <p>6 individuals that indicated, for the public, that they</p> <p>7 would like to testify.</p> <p>8 So if there is someone else who would like to</p> <p>9 as well, we're happy to take you, too. We just want to</p> <p>10 make sure that we get your information, so if you</p> <p>11 haven't had a chance to fill out the form --</p> <p>12 MR. GORDON: I did, actually.</p> <p>13 COMMISSIONER JONES: You did? So come on up.</p> <p>14 And the gentleman who did not, maybe one of the CDI</p> <p>15 staff can have him fill out the form just so we capture</p> <p>16 his information.</p> <p>17 So why don't we start with Ms. Stevenson, and</p> <p>18 then we'll go to Mr. Canetti from the California</p> <p>19 Hispanic Chamber, and then we'll go to the third</p> <p>20 individual.</p> <p>21 Welcome.</p> <p>22 MS. STEVENSON: Thank you.</p> <p>23 I'm Dr. Tanya Stevenson. I'm the CEO of</p> <p>24 Breathe California Golden Gate, the local lung and</p> <p>25 environmental health organization. We are a nonprofit</p> <p>Page 215</p>	<p>1 new tobacco-use technology kids are using, let alone</p> <p>2 know how to control it.</p> <p>3 Through its five-year, 50 million Be The First</p> <p>4 initiative, CVS Health is working to support youth</p> <p>5 smoking prevention, and deliver the first tobacco free</p> <p>6 generation.</p> <p>7 Through partnership with CVS Health, Breathe</p> <p>8 California has been able to provide tobacco prevention</p> <p>9 programming to thousands of youth in low income</p> <p>10 communities throughout the state of California. And due</p> <p>11 to CVS' commitment to creating the first tobacco free</p> <p>12 generation, in 2017 Breathe California of Los Angeles</p> <p>13 County honored CVS Health with their prestigious Breath</p> <p>14 of Life Award.</p> <p>15 In March of 2018, CVS Health announced \$10</p> <p>16 million dollars in new grants and investments to support</p> <p>17 the new endeavor, including a \$500,000 grant to the</p> <p>18 Stanford University School of Medicine.</p> <p>19 CVS has been a leader in putting patients'</p> <p>20 health first, and improving public health here in</p> <p>21 California.</p> <p>22 Other key CVS Health initiatives include</p> <p>23 helping fight against the opioid epidemic. More</p> <p>24 recently CVS Health has demonstrated its commitment to</p> <p>25 public health by expanding their multi-front fight</p> <p>Page 217</p>

<p>1 against the opioid epidemic through enhanced opioid 2 utilization management practices that follow the CDC 3 guidelines, as well as an expanded drug disposal 4 collection program. They also offer free health 5 screenings. 6 Every year through its Project Health 7 campaign, CVS Health offers free biometric screenings 8 for California families to help identify chronic 9 conditions before they become life threatening 10 illnesses. 11 As a network of organizations that strive 12 every day to advance the health of all Californians, 13 Breathe California strongly supports these important 14 initiatives and CVS Health's ongoing commitment to our 15 communities and to our state. 16 Throughout the state, Breathe California is 17 proud to call CVS Health a true community partner. 18 Thank you. 19 COMMISSIONER JONES: Thank you very much. 20 Mr. Canetti from the California Hispanic 21 Chamber, welcome. 22 MR. CANETTI: Thank you, Commissioner Jones, 23 and thank you to the CDI staff as well, and thank you 24 for the opportunity to address you this afternoon. 25 I'm Julian Canetti, president of California's</p> <p>Page 218</p>	<p>1 placed in neighborhoods, and are available for 2 consultation at hours during the day and night when most 3 doctor's offices are closed. 4 The CVS-Aetna merger will provide a nice 5 complement to the services of primary care physicians by 6 arming patients more often and more completely with 7 information, and increasing the number of patient 8 interactions, especially where it is needed with chronic 9 condition care. 10 This merger, we feel, will provide cost saving 11 opportunities to improve the healthcare experience for 12 consumers and businesses. The combined assets of CVS 13 and Aetna will allow the company to be better equipped 14 to meet the health needs of a growing number of people. 15 In closing, I would like to emphasize that the 16 merger of CVS and Aetna will create a healthcare 17 platform that is the patient friendly and achieves 18 needed cost reductions. 19 Thank you. 20 COMMISSIONER JONES: Thank you, Mr. Canetti. 21 It's good to see you again, and thank you for your 22 leadership with the California Hispanic Chambers. 23 Your name is? 24 MR. GORDON: It's Bob Gordon. 25 COMMISSIONER JONES: Bob Gordon. And I think</p> <p>Page 220</p>
<p>1 Hispanic Chambers of Commerce. The chamber is a network 2 of over 65 Hispanic chambers and business associations 3 throughout California, and in that role we represent the 4 interest of more than 800,000 Hispanic business owners 5 residing in California. It also makes us the larger 6 regional ethnic business association in the nation 7 today. 8 I'm here today because healthcare is one of 9 the top priorities and issues of concern to our members. 10 It is not a surprise to anyone here how expensive and 11 time consuming acquiring healthcare coverage can be, and 12 even then it's not clear if it addresses the needs of 13 our members and their employees. 14 Eighty percent of all healthcare costs 15 currently stem from chronic can conditions, which 16 afflict 50 percent of Americans. This can be especially 17 true in Hispanic communities where, for example, 18 diabetes is 84 percent more prevalent among Hispanic 19 than non Hispanic whites, and we are 40 percent more 20 likely to die from diabetes than non Hispanic whites. 21 Because of this shift, we must have different 22 and innovative ways of addressing healthcare needs. In 23 the case of this potential acquisition, we know that 24 pharmacists are often more accessible than primary care 25 physicians. No appointments are needed, they are well</p> <p>Page 219</p>	<p>1 what threw me was you didn't check the little box, Bob. 2 And also you didn't give us an address. 3 So I'm going to ask Mr. Hinz to bring this 4 down to you so you can fill out the rest of it at the 5 completion of your testimony. But welcome. 6 MR. GORDON: Thank you very much. 7 Good afternoon. My name is Bob Gordon, a 8 volunteer, today representing the American Cancer 9 Society Cancer Action Network, which is the advocacy 10 affiliate of the American Cancer Society. Thank you for 11 the opportunity to comment. 12 American Cancer Society Cancer Action Network 13 has worked closely with CVS on campaigns to prevent skin 14 cancer, to provide access to stop smoking products and 15 services, and to end the sale of tobacco products in all 16 of its stores. 17 American Cancer Society Cancer Action Network 18 has seen CVS grow to become a critical player in the 19 healthcare world, and have seen their commitment to 20 provide access to vital healthcare and anticancer needs. 21 But one vitally important point, the lure of increased 22 profits cannot further fragment care for cancer 23 patients. 24 Should this merger move forward, we expect the 25 Department will work closely with the combined entity to</p> <p>Page 221</p>



<p>1 ensure that it will guarantee that patients have 2 affordable access to the medication and healthcare they 3 need to fight and prevent cancer. 4 Thank you. 5 COMMISSIONER JONES: Thank you very much, 6 Mr. Gordon. And I don't have a piece of paper, but -- 7 MR. GALACE: I gave my contact information -- 8 COMMISSIONER JONES: I know. I know. Why 9 don't you go ahead and introduce yourself. It's 10 Anthony -- 11 MR. GALACE: Anthony Galace with the 12 Greenlining Institute. 13 COMMISSIONER JONES: Welcome. 14 MR. GALACE: Commissioner Jones, Deputy 15 Commissioner Rocco, and CDI staff, I just wanted to 16 thank you all for hosting this hearing. 17 Again, my name is Anthony Galace. I'm with 18 the Greenlining Institute, and we're a statewide policy 19 organization committed to racial and economic justice. 20 Greenlining has yet to take a position on the 21 proposed merger between CVS and Aetna, but we are 22 extremely concerned that neither entity has put forth a 23 plan that details how the expected efficiencies and 24 resources accrued will improve economic opportunities 25 for communities of color and other disadvantaged</p> <p>Page 222</p>	<p>1 area and your close work with me and the Department, and 2 as you're aware, the reports from each insurer with 3 regard to their diversity and procurement as well as 4 their diversity in governing boards, are available on 5 our website. So those that want to do a deeper dive 6 with regard to any insurance company, including Aetna, 7 and the extent to which they have bought goods and 8 services from diverse suppliers, whether it's women 9 owned or Latino owned or African American owned or LGBT 10 owned businesses or Native American owned businesses, 11 you can find that information on our website. 12 And I appreciate Greenlining's partnership 13 with the Department in that endeavor. 14 So if there are no other members of the public 15 that wish to comment, I want to thank this panel, and 16 really appreciate your hanging with us for all four 17 hours, and appreciate your sharing with us your views 18 and input on the merger. Thank you very very much. 19 So with that, there are a couple of items that 20 I want to make sure the record is clear that I intend to 21 take notice of. 22 First is rate filings by Aetna to the 23 California Department of Insurance and the Department of 24 Managed Healthcare, and in particular those in which 25 either or both departments found the rates to be</p> <p>Page 224</p>
<p>1 populations, either through their combined supplier 2 efforts or through expanding career opportunities. 3 Furthermore, neither company addresses how 4 they'll use their increased market power to reduce 5 racial and ethnic health disparities as was outlined by 6 the panelist on the second panel who mentioned there is 7 no plan as of yet to open up new branches in 8 disadvantaged, low income neighborhoods across the 9 state. 10 This ignores a majority of the state, which is 11 a majority minority population, and at the same time 12 neither entity, the combined entity, does not have any 13 plan that will show that its board of directors and 14 senior executives will reflect the growing diversity of 15 our nation, which is most prominent here in California. 16 While we await CVS and Aetna's response to 17 these questions that were posed today, we ask that both 18 of them detail plans that will address the needs of 19 California's growing majority, and that the Department 20 scrutinize the extent of these plans and make sure that 21 they are accountable to those who need it most. 22 Thank you so much. 23 COMMISSIONER JONES: Thank you very much. 24 And I would, on the issue of supplier 25 diversity, I appreciate Greenlining's leadership in that</p> <p>Page 223</p>	<p>1 unreasonable, but not limited to those. 2 Second, data over the last five years on the 3 numbers of consumer complaints brought to the Department 4 of Insurance regarding alleged violations of the 5 insurance code by Aetna. 6 Third, various lawsuits that have been filed 7 against CVS and Aetna, some of which were referred to in 8 the hearing today. 9 And fourth, the entirety of the Form A filing 10 and any attendant filings with the Connecticut 11 Department of Insurance associated with this or any 12 other related matter. 13 The Connecticut Department of Insurance is the 14 were domiciliary regulator with which I believe the 15 Aetna parent company has filed the Form A, and so we 16 want to take notice in this proceeding of the Form A 17 filing and any proceedings of the Connecticut Department 18 related thereto. 19 In fairness, Aetna and CVS have asked for an 20 opportunity to respond to the voluminous testimony and 21 written submissions that were made today, and I want to 22 give them a chance to do that. And so they have asked 23 for two weeks in which to accomplish that. 24 I'm agreeable to that with one caveat, and 25 that is if we learn that the Federal Department of</p> <p>Page 225</p>

<p>1 Justice is about to make a decision sometime prior to 2 that, then I may need to accelerate that deadline, and 3 they have consented that caveat.</p> <p>4 All other written materials, written 5 testimony, written comments, unless already submitted 6 here, must be received by the Insurance Department no 7 later than 5:00 p.m. on Friday, June, 22nd, 2018 -- 8 that's this Friday -- and these written materials, 9 written comments, written testimony, can be submitted in 10 one of two ways.</p> <p>11 You can mail them addressed to me, the 12 Insurance Commissioner for the State of California, care 13 of Bruce Hinze, H-I-N-Z-E, Senior Counsel, California 14 Department of Insurance, 45 Fremont Street, 23rd Floor, 15 San Francisco, California 94105.</p> <p>16 Or you may email any written materials to the 17 following email address: The email address is 18 mergercomments -- that's plural -- @insurance.ca.gov.</p> <p>19 We ask that you please include in the subject 20 line, Aetna-CVS so we can distinguish those comments.</p> <p>21 The mailed written comments would need to be 22 postmarked by no later than 5:00 p.m. on Friday, let me 23 just reiterate that. Those are the two ways in which 24 those that are listening or watching this hearing online 25 can submit -- or anybody else for that matter that wants</p> <p>Page 226</p>	<p>1 Aetna for their participation in the hearing and for 2 their testimony.</p> <p>3 I want to thank the other expert witnesses who 4 attended, including the president of the AMA, 5 Dr. McAneny, and also the representatives from the CMA 6 and the consumer groups that were here. I also want to 7 thank my staff, Deputy Commissioner Rocco and Senior 8 Counsel Hinze and all of the other members of our 9 Department of Insurance team that made this hearing 10 possible.</p> <p>11 There is a lot of evidence and testimony that 12 is going to give me a lot to think about and consider. 13 I do remain concerned about the potential 14 anticompetitive effects of the merger. There are 15 obviously competing considerations that have been raised 16 by various parties including the merger proponents, that 17 I will definitely think about and consider, and I look 18 forward to getting the additional written materials from 19 CVS and Aetna as part of that consideration.</p> <p>20 At the end of the day, the question that I 21 think needs to be answered is is this in the public 22 interest? And that's what I will be considering as I 23 think about all of the information that everyone has 24 provided and as a way that competing arguments on the 25 various sides.</p> <p>Page 228</p>
<p>1 to submit information -- in addition to what you have 2 already provided here.</p> <p>3 The reporter is doing a very thorough job 4 capturing everything that was submitted here already, so 5 you need not repeat that, but if you want to send 6 something in in writing, we're happy to receive it.</p> <p>7 So I believe that concludes the housekeeping 8 items associated with the hearing.</p> <p>9 There is a question. Yes, please.</p> <p>10 MR. MORIARTY: Yes. Thank you, sir. CVS and 11 Aetna would like to make sure we get the reports about 12 which the experts testified today in order to respond to 13 them.</p> <p>14 COMMISSIONER JONES: Yes. We're happy to 15 provide you with copies of the written materials 16 provided to us, which we, in some cases, received only 17 at, like, 7:00 last night. But we will be happy to 18 share with you whatever we've received that was referred 19 to or referenced or introduced here at the hearing.</p> <p>20 MR. MORIARTY: Thank you so much.</p> <p>21 COMMISSIONER JONES: Absolutely. Very fair 22 request, and so Mr. Hinze will accomplish that for us.</p> <p>23 So we received a lot of very helpful 24 information and testimony today. I want to thank the 25 representatives from CVS and the representatives from</p> <p>Page 227</p>	<p>1 So thank you very much again, and we 2 appreciate all that have participated in the hearing 3 today, and thanks to all of those that have been 4 listening and watching online as well.</p> <p>5 With that, we are adjourned. Thank you. 6 (Whereupon, the proceeding was 7 concluded at 3:59 p.m.)</p> <p>8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p> <p>Page 229</p>

REPORTER'S CERTIFICATE

I, ANDREA F. DANCE, CSR No. 12865, Certified  
Shorthand Reporter, certify;

That the foregoing proceedings were taken before me  
at the time and place therein set forth, at which time  
the witness was put under oath by me;

That the testimony of the witness, the questions  
propounded, and all objections and statements made at  
the time of the examination were recorded  
stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript  
of my shorthand notes so taken.

I further certify that I am not a relative or  
employee of any attorney of the parties, nor financially  
interested in the action.

I declare under penalty of perjury under the laws  
of California that the foregoing is true and correct.

Dated this 1st day of July, 2018.



ANDREA F. DANCE, CSR No. 12865.

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